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ABSTRACT

A project was conducted in Pennsylvania to develop a stable and competent pool of Alternative Living Arrangement (ALA) direct service personnel to serve all developmentally disabled individuals in need of such services. This goal was to be accomplished through meeting the following process objectives: (1) conducting a comprehensive inventory of existing ALA training resources offered in Pennsylvania: (2) developing a continuing education curricular model for preparing preservice personnel to become direct service ALA personnel: and (3) developing a plan for implementing the preservice ALA curricular model within the state's system of higher education. The report describes the composite procedures used and thoughts and impressions gained during the process described. After the project overview, chapter 2 describes the methodology used to achieve the stated objectives. Chapter 3 discusses the role of the resident advisor, as conceptualized for future service provision. The competencies deemed necessary to perform the function of a resident advisor are identified in chapter 4, along with the rationale for using a competency-based approach. The model curriculum is described in chapter 5 which integrates the role and competencies into a cohesive package, taking into consideration individual program needs and possible course offerings. Issues relating to teaching styles and program evaluation are presented in chapters 6 and 7. Finally, a bibliography of resource materials identified during the course of the project is provided in chapter 8. (KC)

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# A Curricular Model for Preservice Training of Alternative Living Arrangement Direct Service Personnel

Final Report DFI 12.2.1
1978 STATE PLAN
Pennsylvania

Edited by
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# ALA CURRICULUM DEVELOPMENT PROJECT: FINAL REPORT
## OBJECTIVE 12.2.1 1978 PENNSYLVANIA STATE PLAN

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# PREFACE

The 1980s will surely be the "decade of accountability" for Alternative Living Arrangement (ALA) services. The community-based movement will increasingly be taken to task to demonstrate efficiency and effectiveness. The next decade will also bring with it a significantly increased number of new referrals from the large numbers of currently institutionalized developmentally disabled persons. ALA service needs of this new wave of referrals will no doubt be more complex than those of the developmentally disabled residens who are now living in the community. Yet, despite these trends, staff training is one of the most underdeveloped components of our ALA service system (Fiorelli, Heverly, & Conroy, 1979).

With the presentation of this document, it is hoped that Resident Advisor trainig will evolve into a major area of professional preservice training in centers of higher education throughout the Commonwealth. While the beginning of this movement toward preservice training of Resident Advisors has begun, we are far from where we should be in terms of our preservice training capability (Fiorelli, Heverly, & Conroy, 1979).

During the beginning stages of program development for this project, the notion of college level preservice training programs in community-based residential services seemed like a remote dream. In fact, many practitioners in the field, including ALA providers, staff trainers, and bureaucrats literally laughed at the idea of possible degree programs for Resident Advisors. For example, an official response to our initial training proposal from a major state office characterized Resident Advisors as "front line non-professional staff." This same letter went on to state that "it was disappointing in that academia plans to marshal it's stereotyped pedagogical cannons to slaughter a mosquito ... proposing overkill for the mosquito, who has perished countless times under the onslaught of training monies but somehow manages to resurrect itself." Upon reading the contents within, I am sure the reader will indeed be overwhelmed at the complexity and importance of the front line responsibilities of the Resident Advisor. In this regard, it should be abundantly clear that the Resident Advisor's role in the delivery of comprehensive and habilitative ALA services can never again be characterized as "non-professional."

It is our hope that colleges and universities throughout the Commonwealth will "marshal their pedagogical cannons" to provide the field with a fully stocked manpower pool of preservice trained Resident Advisors who will be ready and able to meet the challenges ahead in community-based residential services during the 1980s.

Joseph S. Fiorelli

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## Chapter 1

# OVERVIEW

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Although the community-based services movement has grown dramatically in recent years, it has far from crested National trends in deinstitutionalization (Conroy, 1977; Scheerenberger, 1976) show that the impact of the deinstitutionalization effort has largely been manifested by "inter-institutional relocation" rather than by successfully placing developmentally disabled citizens in normalized alternative living arrangements.[1] Thus the community has not as yet felt the full impact of the deinstitutionalization movement; however, recent judicial decisions dictate that such an impact is not far ahead.

To meet the sharply escalating demand for quality ALA services and insure that a stable pool of well trained direct service ALA personnel is in place by the 1980s, it is imperative that a continuing educational curriculum be developed which is responsive to the preservice training needs of ALA direct service personnel throughout the state. Design for implementation (DFI) 12.2.1 of the 1978 Pennsylvania Developmental Disabilities State Plan (Pennsylvania, 1978, p. 358) was identified as the conduit through which the necessary training resources could be identified and a comprehensive plan developed to begin to meet the manpower challenge ahead in the field of ALA services. It was the intent of this project to begin to meet this challenge by first conducting an inventory of available ALA training resources within the Commonwealth and secondly developing a comprehensive model curriculum for preservice training of ALA direct service personnel.

The objectives of the project are best understood by studying its supporting rationale. Central to the project were the following notions:

1. that the current momentum for community-based ALA services is a serious long-term service commitment;
2. that staff stability is a critical element in building a supportive residential environment and staff training will enhance staff stability;
3. that ALA services should serve all DD populations including the more severely mentally, physically and behaviorally impaired;

---

[1] Alternative Living Arrangement Services are community-based residential alternatives to institutional placement (e.g., group homes, co-residential apartments, etc.) and may take the form of individual or group placement in a residential setting which provides an appropriate level of program and supervision necessary to promote and/or maintain the highest degree of normalization (Wolfensberger, 1972), independent living and family life as is possible.

4. that ALA services should be more than just custodial efforts and should contribute significantly to client growth vis-a-vis working with the client and his/her family so that he/she may achieve increasing levels of independence and adjustment to community living.

The first notion has been validated by the growing acceptance of the principle of normalization (Bank-Mikkelsen, 1969; Nirje, 1970; Wolfensberger, 1972), by the expanding body of "least restrictive" litigation over the past decade mandating the creation of more normalized community alternatives to institutionalization (e.g., Lake v. Cameron, 1966; Wyatt v. Stickeny, 1974; Deinstitutionalization wins, 1977; Haldeman v. Pennhurst, 1977) and by the dramatic increase in the number of developmentally disabled persons being referred for community placements (O'Connor, 1976). Hence, the seriousness of society's commitment to community-based services indeed appears genuine and is deeply rooted in its human service ideology, its socio-political structure and subsequently in its laws (Thurman & Fiorelli, 1979).

As the commitment to ALA services continues to broaden, the need for trained competent direct service personnel will become increasingly critical (PARC, 1975; Olsen, 1977; Fiorelli, 1977; O'Connor, 1976). Among the MR service population in Pennsylvania alone, the state Office of Mental Retardation has stated that one of its primary service goals for FY 81-82 is to establish programs providing for a total of 10,000 ALA slots. This number when coupled with the number of ALA slots which may be developed within the private sector and non-MR funding streams indicates a welcome but overwhelming challenge for manpower training and development in ALA services during the next few years.

The second notion, that ALA services should foster a supportive relationship between the consumer of service and the direct service staff person, has been submitted as a recommendation to the White House Conference on Handicapped Individuals (Report and Voting Recommendations, 1977). The emerging concept that direct service staff should play an active, habilitative role is reflected in the service titles now widely in use (e.g., resident advisor, resident counselor, co-resident as opposed to client care worker, ward attendant or custodian). However, given the present high turnover rate of direct service ALA staff (Dellinger & Shope, 1978, report a median turnover rate of 6.8 months) program continuity and the building of supportive relationships are more likely to be myths rather than realities.

Reasons often cited as contributing to high ALA staff turnover include (a) "burnout effects" (Report and Voting Recommendation, 1977) which may result from the lack of skills needed to adequately maintain client growth and well being (Dellinger & Shope, 1978); (b) lack of career advancement; (c) low pay; and (d) long hours of responsibility with little privacy (O'Connor, 1976). Thus, the notion of program continuity and relationship building would appear seriously undermined because the current ALA service environment generally does not provide a feeling of competence about one's abilities, a salary equal to responsibility or a professional future.

The third ALA service notion, that of providing community-based services to the more severely disabled, is perhaps the greatest challenge and ultimate test of the ideological and socio-political commitment to normalization. This service commitment was addressed by the Pennsylvania Governor's Conference on Handicapped Individuals (1977) as well as the White House Conference on Handicapped Individuals via the Report and Voting Recommendations (1977). In both cases the importance of providing severely disabled persons with least restrictive community living arrangements which are supportive and facilitate client growth is stressed. Indeed the momentum towards normalized ALA services was greatly facilitated by the "snake-pit" horror stories regarding the treatment of severely and profoundly developmentally disabled citizens. Wolfensberger (1972) recognized this challenge and emphasized the need for "normalizing activations" which will be necessary to integrate the severely and profoundly disabled into the mainstream of the community.

More recently, Scheerenberger and Felsenthal (1977) have advocated for "agressive Pursuit" of ALA services and state that "even the more severely retarded, multiply handicapped individuals were making a most successful adjustment to community living..." (p.7). In Pennsylvania, U.S. District Court Judge R. J. Broderick ruled that the incarceration of residents at Pennhurst violated the residents constitutional and statutory rights (Haldeman v. Pennhurst, 1977) and that "given appropriate community facilities, all residents at Pennhurst, even the most profoundly retarded with multiple handicaps, should be living in the community." In discussing the expertise necessary to successfully program for the severely disabled Barrett (in press) states that "if community environments are to serve severely handicapped persons better than institutional environments, they must undergo both extensive and intensive modification." She further points out that the impact on the general public and, thus, the acceptance of normalization by the public at large "will depend on the extent to which community environments can be modified to normalize the behavior of the people they are now being asked to serve." Hence it is primarily the competence of direct service ALA personnel which will determine the success or failure of community placements for the more severely developmentally disabled.

If one accepts the last service notion, that ALA services should foster adaptive behavior and development of independence, it follows that direct service ALA staff either (a) require professional training or (b) must be given ready and continued access to program consultants or a core team who may design developmental programming and closely monitor and adjust intervention strategies. It was the feeling of the project staff that the former, professional level preservice training, would offer far and away the superior long-term benefit programmatically and, in time, may serve to eliminate or reduce many of the factors which contribute to high ALA turnover rates and program failure. Yet in the face of our apparent service commitments and the dramatic demands soon to be placed on the ALA system, there are only six comprehensive, ongoing preservice ALA training programs preparing the Commonwealth's ALA manpower to assume the responsibility for developing quality ALA programming for all developmentally disabled populations regardless of age or severity or multifaceted nature of disability (Fiorelli, Heverly & Conroy, 1979).

The current state-of-the-art in ALA training requires that ALA providers either design their own programs and/or seek inservice resources from a host of other agencies scattered about the community, region, state and sometimes beyond. The Pennsylvania Office of Mental Retardation reports (Report and Analysis, 1977, p.3) that over half of all CLA staff training occurred outside of the participating program's county of operation, with 15% of CLA program staff training occurring either out of state or out of region. Should this situation continue, the result will be a severe drain on the ALA provider and may serve as an impediment to the mission of delivering quality, habilitative ALA services to the developmentally disabled consumer. It is reasonable to believe that preservice training of high quality could enhance ALA service delivery as well as act to conserve the limited resources of the ALA provider (i.e., funding for preservice training could come from sources outside the OMR-CLA Program).

The need for adequate preservice training for ALA direct service personnel is demonstrated by the intensive inservice training which is often invested in new direct service personnel by ALA service providers. The tragic irony of the inservice training effort is that a very high proportion of trained personnel turnover within one year (Dellinger & Swope, 1978) leaving the service provider with nothing to show by expended resources. Much of this turnover is due on the transient orientation many direct service ALA personnel have toward their "job" (Fiorelli, 1977). Many direct service personnel view ALA employment as temporary and are marking time until they find a "better" job or get accepted into an educational program to train for a more professional career. By providing preservice programs designed to attract students with a sincere interest in ALA service the high rate of turn-over could be dramatically reduced. High quality training programs on which service providers can rely must be readily available throughout colleges and universities within the Commonwealth. This is not to imply that inservice training is unimportant; such training, however, must be viewed as enrichment and adjunctive to systematic preservice training geared to provide the basic entry level skills necessary to provide quality ALA services.

Speaking to the need for professionalization of direct service ALA personnel, PARC suggested that the Pennsylvania Department of Public Welfare "redefine the role of (ALA) non-professionals...the personnel who carry the responsibility for the day-to-day care and training of the disabled in residential settings" (PARC, 1975). The Office of Mental Retardation has also stressed the importance of professional staff development, while acknowledging that to date utilization of college and university training resources have been sporadic (Report and Analysis, 1977). Olsen (1977) stated that "fundamental to the continuing success of the Office of Mental Retardation's (OMR) CLA Program and, indeed to the evolution of all community-based human services, is the professional development of service staff and the availability of well trained manpower from the Commonwealth's colleges and universities" (p.1). Many authors (e.g., O Connor, 1976; Olsen, 1977; PARC, 1975; Fiorelli, 1977) have suggested the University and/or Junior College as a possible training source for ALA direct service personnel. Recognition of this rationale led the Pennsylvania DD Council to focus upon the critical need for trained ALA manpower, and ultimately to the provision for this project.

## PROJECT OBJECTIVES

The overriding purpose of the project was to enhance the probability that Pennsylvania would have a stable and competent pool of Alternative Living Arrangement (ALA) direct service personnel to serve all developmentally disabled individuals in need of such services. This goal would be accomplished through meeting the following process objectives:

1. conducting a comprehensive inventory of existing ALA training resources offered by the Commonwealth's state departments and post-secondary schools;

2. developing, with the input of an advisory board representing a variety of organizations with significant interest in ALA development, a continuing education curricular model for preparing preservice personnel to become direct service ALA personnel;

3. developing a plan for implementing the preservice ALA curricular model within the Commonwealth's system of higher education.

The remainder of this document reflects the composite procedures used, thoughts and impressions gained during the process described. Chapter 2 describes the methodology used to achieve the above objectives. Chapter 3 discusses the role of the resident advisor, as conceptualized for future service provision. The competencies deemed necessary to perform the function of a resident advisor are identified in Chapter 4, along with the rationale for utilizing a competency-based approach. The model curriculum is described in Chapter 5 which integrates the role and competencies into a cohesive package, taking into consideration, individual program needs and possible course offerings. Issues relating to teaching styles and program evaluation are presented in Chapters 6 and 7. Finally, a bibliography of resource materials identified during the course of the project is provided in Chapter 8.

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## Chapter 2

## METHODOLOGY

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Program Liaison Coordinator

### A. ADVISORY COMMITTEE

At the outset it was believed that only through the collaborative input of all sectors committed to providing quality ALA services could a truly responsive and meaningful curriculum model be developed. Hence, an advisory committee composed of persons having recognized ALA service expertise was formed. Representatives from the following groups served on the advisory committee: a) public and private ALA providers, b) developmental disabilities consumer groups and advocates, c) state and county administrators, and d) developmental disabilities experts from colleges and universities. This advisory committee served throughout the project.[1]

The functions of the advisory committee included: a) provision of information to the project staff, b) review and integration of data collected during the project c) and assistance in formulation of workable strategies for dissemination and implementation of the curricular model. Furthermore, as the committee was constituted as a working group, it was divided into subcommittees, each corresponding to the objectives of the project. Advisory committee members chose to serve on one more of the following subcommittees:

Curriculum Screening: to evaluate existing resources identified through the training resource inventory, and literature searches.

Functions and Competencies: to define the areas and sub-areas a curriculum should address; to list the competencies for each area and assign priorities; and to develop instrumentation to evaluate the high priority competencies.

Instructional Format: to facilitate the presentation of the curriculum with regards to the academic level of the material, instructional media and the format of the presentation.

Implementation: to develop strategies for persuading the Commonwealth's centers of higher education to utilize the curricular model.

The activities of each of these committees is described below:

1. Curriculum Screening Subcommittee: To identify relevant ALA training resources, project staff conducted two computerized literature

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[1] As several members were unable to continue their participation throughout the grant period, membership changes were necessitated. A complete list of advisory committee members and their affiliation is provided in Appendix A.

searches using the ERIC (Educational Resources Information Center) and NICSEM (National Information Center for Special Education Materials) data bases, neither of which provided substantive information. This necessitated that the project rely upon manual search strategies and information from "experts" in the field to identify relevant resources. Sources examined included bibliographies, books, journals and training packages, which were obtained through suggestions from project staff, the advisory committee and professionals working with developmentally disabled people. Furthermore, a questionnaire was sent to all member programs of the American Association of University Affiliated Programs (UAPs) and the state Mental Health/Mental Retardation Office in all 50 states. The respondents were asked to supply pertinent information concerning applicable training materials, resources, program aids, etc.

In all, over 300 requests for information were sent out. When received, much of this material (books, journal articles, training packages, etc.) was reviewed by the Curriculum Screening subcommittee of the advisory committee. Once a resource was reviewed, pertinent information about it was abstracted and kept or file. The subcommittee discovered that little more than half of the vast amount of material reviewed was relevant to the project's goals. However, in the course of their review, they discovered additional bodies of literature which might be pertinent and made suggestions to staff as to what these might be (e.g., educational systems. community resource programs, medical services). Also, this subcommittee made suggestions to the staff and the Functions and Competencies subcommittee regarding areas of content which must be addressed in a comprehensive curriculum (e.g., nutrition, normal child and adult development, counseling, etc.). The materials collected and reviewed by the Curriculum Screening Subcommittee have been placed into a library at the Temple UAP, and are available as reference material to interested individuals. Pertinent material is also listed in a bibliography (see Chapter 8) which will be of use to students, teachers and other persons providing training to resident advisors.

2. Instructional Format: In conjunction with the works of the Curriculum Screening subcommittee, the Instructional Format subcommittee reviewed materials representative of several instructional formats.The subcommittee presented examples of books, audio-visual and video cassettes, films, filmstrips, slide presentations, etc. for consideration. The subcommittee felt that the use of a particular modality of instruction was contingent upon the purposes and goals of a particular training program and that the needs of a particular group of students, in a particular geographical location, being trained for specific programs of service will in part dictate the most advantageous format. The materials presented, some of which are included in Chapter 8, Bibliography, are seen to be adjunctive supports to the curriculum presented in this document, and should be tailored to the demands of the target population, length of training, focus of training and so forth.

3. Functions and Competencies: The initial task of the Functions and Competencies subcommittee was the identification of the current role of the residential advisor. It was presumed that the committee, comprised as it was of individuals integrally involved in provision of alternative community residential services, would be familiar with the regular functions

and duties of resident advisors. This information would be used to identify target areas for future training. However, the focus of the subcommittee broadened to include not only present roles and functions but "ideal" roles and functions, particularly in light of the mandate to provide quality services to severely and profoundly impaired developmentally disabled individuals. Thus, a second question needed to be asked: What should the resident advisor's role be, particularly as it differed from what the functional role actually was? These questions were asked of the full Advisory Committee via a questionnaire, which also asked committee members to prioritize the five most important competencies a residential advisor should have. It was decided by the Advisory Committee and project staff from the outset that the curriculum developed would be competency-based. Rationale for this decision is provided in a subsequent chapter. The prioritized competencies of the Advisory Committee served as a foundation upon which the subsequent curriculum was based. However, in addition to them, competencies were also identified by means of additional contracts with service providers, administrators, parents, consumers and literature review of pertinent current materials. Competency documents developed for other disciplines (most notably special education) were also reviewed to determine the applicability of specific competencies from those areas to resident advisorship. This effort resulted in the identification of approximately 500 individual competency statements which are listed and discussed in Chapter 3 along with the questionnaire discussed above.

The Functions and Competencies subcommittee constructed a matrix which asked respondents to rate each competency on five dimensions, namely: a) is this competency one a student should be able to demonstrate during or at the end of training? b) was the competency specific enough to communicate its main intent (the importance of the underlying skill)? c) whether the competency was specific enough to assist in generating instructional activities and guiding instruction? d) whether it was specific enough to assist in evaluating student and program progress? and e) a general rating statement was requested. A sample page of the competency matrix with sample competencies is provided in Appendix B.

In addition to the Advisory Committee, a resident Advisor Review Board was asked to comment upon the competency matrix. This Review Board was comprised from a list of resident addresses currently working in Pennsylvania's Community Living Arrangements, compiled through recommendations from advisory committee members, as well as requests for assistance placed in the Pennsylvania Association of Community Residential Programs (PACRP) newsletter. In addition to the questions on the response grid, all respondents were asked to identify additional areas of competencies which were not addressed and should be. Expert consultants were also commissioned to review and comment on the list of competencies.

The general consensus was that most competencies, and certainly all areas covered in this initial compilation were appropriate. However, several additional areas were identified as needing coverage. These included: peer relationship building, comprehensive delivery service system, advocacy, group processes, personal growth and normal development. Individuals hired as consultants with noted expertise in these areas were asked to write competency statements for inclusion in the final curriculum. Finally, all the competencies were reviewed by project staff, taking into consideration the thoughts and suggestions of all asked to participate in the review.

The final product of that effort is presented in Chapter 4 of this document.

4. Implementation Plan: The Implementation Plan subcommittee met to develop strategies for encouraging Pennsylvania's colleges and universities to implement the model curriculum. A major consideration was that a great need existed for flexibility both on the part of the schools and in the curriculum. This is reflected in the modular design of the model curriculum described in Chapter 5. Consideration was also given to identification of benefits to colleges and universities, sources of funding, methods of obtaining funding for curricular development and planning, as well as a means to develop faculty. Specific recommendations were integrated into the overall curriculum as described in this report.

## B. SITE VISITS

Site visits were made by committee members and project staff to programs identified during the resource search as having significant training components from which valuable experience could be gained. Committee members and project staff also attended conferences and workshops which addressed alternative living arrangement issues. A listing of programs visited and conferences attended follows.

a. Programs visited:

- --Metropolitan Toronto (Canada) Association for the Mentally Retarded
- --University of Vermont
- --Habilitative Services Program, Clarion State College, Clarion, Pa.
- --Florida Association of Rehabilitation Facilities Training
- --Achievement Place, Kansas University
- --Concerned Care Inc., Kansas City, Missouri
- --Rosewood Center, Owingo Mills, Maryland

b. Conferences attended:

- --Developing Residential Alternatives for the Aged and Disabled Conference (Hershey, Pa. December, 1978)
- --Shaping the Future: A National Forum on Community-Based Residential Services and Facilities for Mentally Retarded People (Phoenix, Arizona, December, 1978)
- --Region IX American Association for Mental Disabilities (Rehoboth Beach, Delaware, October, 1978)

--Federal Programs Information and Assistance Project (in conjunction with the Philadelphia, Pa. chapter of the United Cerebral Palsy Association, November, 1978)

The products of these various grant activities: discussion of the role of the resident advisor, the listing of functional competencies of resident advisors, the model curriculum for preservice training, considerations for implementation and a bibliography of pertinent materials will now be presented.

3

## Chapter 3

# THE ROLE OF DIRECT SERVICE PERSONNEL IN PROVIDING ALA SERVICES: A SEARCH FOR DEFINITION

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## Issues related to Definition

As the principle of normalization (Nirje, 1970; Wolfensberger, 1972) continues to gain acceptance, community-based alternative living arrangement (ALA) services will become the cornerstone of a residential service system based upon creating "home like" residential settings. The goal of enabling developmentally disabled residents to achieve as normalized and independent a life style as possible in the community has already gained wide spread attention among both consumer groups (e.g., NARC, 1976) and professionals in the human services field. (Budde & Edwards, 1978). This change in residential service system ideology over the past two decades has been characterized by the shift from large, centralized, custodial residential service models to more dispersed, community-based, developmental models offered in the "least restrictive" residential setting. (Bruininks, Thurlow, Thurman & Fiorelli, in press.)

Recently it has been suggested that the opportunity to return to the community and partake in the mainstream of community life be extended to the fullest range of currently institutionalized developmentally disabled citizens (e.g. Katz, 1972; Soforenko & Macy, 1978). Social advocates, using the courts as a forum for change, have greatly enhanced and have tried to accelerate the establishment of alternative living arrangements for those individuals who are currently institutionalized. We in Pennsylvania have been particularly sensitive to this pressure for change by the recent Halderman v. Pennhurst (1977) decision which mandated the creation of alternative living arrangements for all residents of Pennhurst, including the most severely and profoundly handicapped. Thus as the residential service population to be served in the community becomes more severely impaired, the functions of direct service personnel in ALA services will necessarily become more demanding. This shift in function will require more sophisticated expertise on the ALA direct service manpower levels which is commensurate with the increased residential service needs of those significantly more impaired persons entering the community-based residential service system.

In defining the role of direct service personnel in ALA service (i.e., those staff who deliver and maintain the day to day ALA program) one confronts a very difficult task given the high state of change which presently exists throughout all levels of the residential services system (PACRP, 1979). The present state of the art is formative and turbulent. There has been an absence of a unified and systematic approach to definition of resident advisor roles and functions in light of the increased level of competence which will be necessary if resident advisors are to adequately serve the more impaired developmentally disabled. The objectives of the present chapter are: a) to present the current view from the field regarding resident advisorship, and b) to outline a process for redefining the role and functions of the resident advisor in light of recent trends (e.g., to provide a wider spectrum of residential alternatives to a wider functional range of developmentally disabled residents).

## The Process of Definition: Going through Muddy Waters

The process of definition is hampered by several interrelated variables which have not previously been addressed as a whole, namely: who is to be served, what are their service needs, what model of service best suits these needs in a manner that is normalized, developmental and least restrictive? All of these questions directly impact upon planning for ALA manpower training and service delivery models. For example, the expanded functional range of ALA residents will necessarily involve the creation of new types of ALA programs and service support models to accommodate the diverse needs manifested by the new wave of ALA residents who will be referred for community living. A number of authors have discussed the need for diversity of ALA settings and have outlined residential care models which demonstrate the need for a service system capable of addressing a wide range of individual resident needs (e.g., Bruininks, et al., in press; Fritz, Knowlton & Wolfensberger, 1971; Katz, 1968; PACRP, 1979; Thurman & Fiorelli, 1979) in a manner that insures the progression of developmentally disabled residents to the most developmental and least restrictive residential alternative.

Due to the inherent diversity associated with ALA services for the developmentally disabled, specialization becomes a necessary consideration in the definition process. Already the ALA service system is divided into adult and childrens services, and to a limited extent, behavior shaping services. The developers of the model curriculum herein recognized the need for specialization and included several curricular units and specialized tracks which emphasize specific resident needs. While separation of childrens and adult services was seen as an important function, for the purpose of personnel training and definition of the resident advisor's role, this degree of specialization (i.e. separate training tracks and job classifications for personnel working with children and adults) was not viewed as necessary. However it was felt that, given the severe and special needs of many long-term institutionalized developmentally disabled residents, a specialization in serious behavioral needs as well as in the special needs of medically complex, profoundly impaired and multiply handicapped residents was appropriate for inclusion in the model curriculum.

In terms of defining the role (i.e. occupational description) and the function (i.e. duties and responsibilities) of ALA direct service manpower levels, there has been to date little progress. We are essentially working in an area which has not been consummated and which is viewed from both inside and outside the field as "nonprofessional". There has only recently been limited attempts to systematically define the resident advisor's role and function keeping in mind the who is to be served, what are their residential service needs, and how will they be served perspective discussed earlier. As a first step to facilitate a unified approach to defining resident advisor roles and functions, the current state of the art regarding direct service manpower levels is presented below in the hope that we may move toward development of a uniform perspective that integrates the best viewpoints from the field.

## PACRP's View of Resident Advisor Roles and Functions.

The Pennsylvania Association of Community Residential Programs (PACRP, 1978) has submitted a formal model for staffing ALA residential services to the Commonwealth for consideration. Shown below are the ALA direct service manpower levels exactly as they appear in the PACRP (1978) model.

### LEVEL I: RESIDENTIAL SERVICES TRAINEE

Definition: This is an entry level trainee position in providing guidance to mentally retarded persons living in community residential programs.

Employees in this class learn to guide and assist mentally retarded persons to live and function as independently as possible in the community. Employees in this class learn to assist mentally retarded persons develop self-help skills, secure proper medical care, use their leisure time and take advantage of community resources. After completing a planned training program, the employee would function under the general supervision of a project supervisor. Work would be reviewed regularly for effectiveness and adherence to project policies and procedures.

Examples of Work Performed:

Assist in developing and implementing individual program plans with residents to help them learn social and self-care skills, including cooking, etiquette, toilet training, housekeeping, etc.

Assist in maintaining the housing unit in good condition and in accordance with fire and safety rules and regulations.

Supervise recreational and social activities and instruct residents in the use of community facilities.

Attend staff meetings and training sessions.

Complete progress reports.

Required Knowledge, Skills, and Abilities:

Ability to work with people

Ability to understand mental retardation and its social implications.

Ability to understand programming principles.

Ability to communicate clearly.

Ability to understand principles of normalization.

Ability to learn and work in the following areas:

Individual program
Counseling
Resident Medical Care
Behavior Management
Service Coordination with other agencies
Coordination with family
Casework

Minimum Experience and Training:

Intelligence and interest in human services are the only requirement.

## LEVEL 2: RESIDENTIAL SERVICES WORKER

Definition: This is a journeyman level guidance position in working with mentally retarded citizens in community residential programs.

Employees in this class guide and assist residents to live and function as independently as possible with the community. They develop and implement individual program plans and coordinate and arrange for specialized services and perform extensive public contact work. They insure that the health and welfare needs of the residents are met at all times. They supervise the daily activities of the residential facility and are responsible for the management of the facility in the absence of the project supervisor.

Work is performed under the general direction of the project supervisor and is revised periodically for effectiveness and adheres to established policies and procedures.

Examples of Work Performed:

Develops and implements individual program plans to improve the social and self-care skills of the residents living in the facility.

Assists in arranging and coordinating the provision of special services, including speech therapy, psychotherapy, etc.

Supervises social and recreational activities.

Responds appropriately to emergency situations.

Completes goal plan, progress evaluations, and other reports as required.

Assists in maintaining the facility in a safe and secure manner.

Guides residents in the proper use of their civil rights.

Counsels residents with mental and emotional problems.

Attends staff meetings, case conferences and learning sessions.

Required Knowledge, Skills, and Abilities:

Knowledge of the principles and methods of rehabilitation for the mentally retarded.

Knowledge of normalization principles.

Knowledge of behavior management and program planning principles.

Ability to take direction as well as direct others.

Ability to make sound judgement regarding the health and welfare of mentally retarded persons and respond appropriately in emergency situations.

Knowledge of mental retardation and its social implications.

Ability to maintain effective working conditions.

Ability to work in the following areas:

Counseling
Resident Manager Care
Behavior Management
Resident Planning
Service Coordination with other agencies
Family Relationships
Casework

Minimum Requirements:

Two years of college or two years experience in human services or any combination thereof. The completion of an approved training course may substitute for one year of experience.

## LEVEL 3: RESIDENTIAL SERVICES SUPERVISOR

Definition: This is a guidance and supervisory position in working with mentally retarded persons in community residential programs.

Employees in this class supervise a group home, apartment or other community residential project staff in assisting the mentally retarded residents of the facility learn the self-help skills they need to know to live as independently as possible. They have primary responsibility for the health and safety of the residents and for developing and implementing individual program plans. Extensive public contacts and good working relationships with personnel from local and state agencies are required to insure the project operates effectively and resident needs are met. The employee must insure that the facility is operated in a safe, secure and lawful manner and in accordance with established policies, rules and regulations. Employees may exercise control over a home maintenance budget and may be responsible for project expenditures and receipts.

Work is performed in conformance to established policies and procedures and under the general supervision of the residential project director. Work is evaluated through direct observation, reports, conferences and an analysis of project effectiveness.

Examples of Work Performed:

Supervises a small staff of residential service workers in operation of a community living arrangements project designed to assist and support mentally retarded people to live as independently as possible.

Develops, implements and monitors individual program plans.

| | |
|---|---|
| Resident Medical Care | Counseling With Family |
| Behavior Management | Casework |

Minimum Requirements:

Bachelor Degree or four years experience in human services or any combination thereof. The completion of an approved training course may substitute for one year of experience.

PACRP has also included a salary allocation guide (shown in Table 1), for the direct service as well as administrative manpower ALA levels. Actual salaries vary a great deal across the Commonwealth.

TABLE 1

PACRP RESIDENTIAL SERVICES STAFFING MODEL ALLOCATION GUIDE

| Title | Number of Residents | Number of Projects | Salary |
|---|---|---|---|
| Residential Services Trainee | (Direct Service Level 1) | | $ 6,489-$ 8,513 |
| Residential Services Worker | (Direct Service Level 2) | | $ 7,428-$ 9,785 |
| Residential Services Supervisor | (Direct Service Level 3) | | $ 8,513-$10,724 |
| Residential Program Director I | 6-12 | 1-2 | $10,054-$12,694 |
| Residential Program Director II | 17-40 | 3-5 | $11,540-$14,611 |
| Residential Program Director III | 41-64 | 6-8 | $13,281-$16,822 |
| (II level requirements apply if program spans county MH/MR system areas) | | | |
| Residential Program Director IV* | 65+ | 9+ | $15,296-$19,404 |
| (III level requirements apply if program spans county MH/MR system areas) | | | |
| Residential Program Director V* | (Region or Statewide program) | | $17,624-$22,357 |

*Not approved by the Commonwealth

## The States' View of Resident Advisor Rules and Functions

The above community-based residential staffing model designed by PACRP was submitted to the Commonwealth for consideration in the development of the Commonwealth's official class specifications for residential services staff. The Department of Public Welfare, Office of Mental Retardation, in collaboration with the Bureau of Manpower Planning have recently developed and approved a set of official class specifications for residential service personnel based largely upon the PACRP staffing model. The only major difference between the two staffing models, is that the Commonwealth's model is presented more generically to include other residential personnel in addition to Resident Advisors working in ALAs (e.g., mental health, aging, etc.). The final draft of Pennsylvania's manpower class specifications (Bureau of Manpower, 1979) for residential service personnel working in county programs is shown below.

### LEVEL I: RESIDENTIAL PROGRAM TRAINEE

Definition: This is beginning level work of a training nature in working with program clients in a county Human Services Residential Program.

An employee in this class participates in a training program designed to develop basic knowledges, skills, abilities, and attitudes necessary in assisting program clients to live and function as independently as possible in the community. As knowledges and skills are acquired through training, further developmental assignments are given for the application of skills and abilities to an actual work situation. Training and work assignments are performed under the close supervision of a Residential Program Director or Residential Program Supervisor who reviews work in progress and upon completion for effectiveness and adherence to program policies and procedures.

Examples of Work Performed: Participates in a training program designed to develop the knowledges, skills, abilities, and attitudes necessary to assist program clients to live and function as independently as possible in the community.

Assists in developing and implementing individual service plans for program clients to help them learn self-care skills such as cooking, grooming, toilet training, money management, and housekeeping.

Assists program clients in developing social skills such as taking part in conversations, participating in home activities and practicing good manners in dealing with people.

Assists with or conducts, under close supervision, recreational and social activities.

Instructs program clients in the availability and use of community resources and facilities.

Assists in maintaining the residential unit in good condition and in accordance with applicable fire and safety rules and regulations.

Attends staff meetings and conferences as assigned.

Learns to maintain necessary administrative records and reports.

Performs related work as required.

Required Knowledges, Skills and Abilities: Knowledge of pertinent community resources and facilities.

Ability to develop and maintain a sympathetic and understanding attitude when working with program clients.

Ability to learn and apply simple principles and methods of rehabilitation for the program clients.

Ability to read and write.

Ability to learn to keep and maintain simple records.

Ability to follow simple oral and written instructions.

Ability to work with people.

Minimum Experience and Training: No previous experience and training required.

## LEVEL 2: RESIDENTIAL PROGRAM WORKER

Definition: This is journeyman level work of a guidance nature in working with program clients in a county Human Services Residential Program.

An employee in this class guides and assists program clients in learning to live and function as independently as possible in the community. Important aspects of the work include participation in the development and implementation of individual service plans, coordinating and arranging for the provision of specialized services, counseling program clients on simple problems, and performing public contact work as required. An employee may function as a lead worker in training and guiding Residential Program Trainees. Work is performed under the general direction of a Residential Program Director or Residential Program Supervisor who reviews work for effectiveness and adherence to program policies and procedures through conferences and reports.

Examples of Work Performed: Participates in the development and implementation of individual service plans designed to improve the social and self-care skills of program clients.

Assists in coordinating and arranging for the provision of specialized services such as speech therapy, psychotherapy, medical and dental care.

Counsels program clients to help them more effectively deal with matters such as personal problems, personal values, and job responsibilities.

Assists in the training and guidance of Residential Program Trainees.

Supervises social and recreational activities.

Responds appropriately to emergency situations.

Assists in maintaining the residential unit in a clean, safe and secure manner.

Prepares program client progress reports, and other reports as required.

Attends staff meetings, conferences and learning sessions.

Performs related work as required.

Required Knowledges, Skills and Abilities: Knowledge of pertinent community resources and facilities.

Knowledge of the basic principles and methods of rehabilitation for the program clients.

Knowledge of basic behavior management and program planning principles.

Knowledge of applicable health and safety measures.

Ability to develop and maintain a sympathetic and understanding attitude when working with program clients.

Ability to make sound judgments regarding the health and welfare of program clients and respond appropriately in emergency situations.

Ability to take direction as well as direct others.

Ability to establish and maintain effective working relationships.

Ability to express ideas clearly and concisely, orally and in writing.

Minimum Experience and Training: One year of experience as a Residential Program Trainee.

or

Two years of experience in a Human Services Agency working with the mentally disabled, the elderly, or children and youth.

or

Two years of college which includes courses appropriate to the Human Services field.

or

Any equivalent combination of experience and training.

## LEVEL 3: RESIDENTIAL PROGRAM SUPERVISOR

Definition: This is supervisory work in a county Human Services Residential Program.

An employee in this class serves as the assistant to a Residential Program Director II or III in the supervision of Residential Program Workers and Trainees in a county Human Services Residential Program who are engaged in assisting program clients to live and function as independently as possible in the community. Work involves training, assigning, monitoring and evaluating the work of Residential Program Workers and Residential Program Trainees; assisting in the development, implementation and monitoring of individual service plans; counseling program clients on routine problems; insuring that the residential units are maintained and operated in a safe, secure and lawful manner; and reporting any operational, staff, or client problems to the director. Work is performed in conformance with established policies and procedures and under the supervision of a Residential Program Director II or III who reviews the work to determine quality and achievement of established objectives through conferences, reports and observation.

Examples of Work Performed: Serves as the assistant to a Residential Program Director II or III in the supervision of Residential Program Workers and Residential Program Trainees in a county Human Services Residential Program who are engaged in assisting program clients to live and function as independently as possible in the community.

Trains, assigns, monitors and evaluates the work of residential program staff.

Assists in developing, implementing and monitoring individual service plans designed to improve the social and self-care skills of program clients.

Counsels program clients to help them more effectively deal with matters such as personal problems, personal values, and job responsibilities.

Insures that the residential unit is maintained and operated in a safe, secure and lawful manner.

Insures the provision of specialized services such as speech therapy, psychotherapy, medical and dental care to meet individual clients needs.

Maintains effective working relationships with personnel from state and local agencies and families to coordinate the delivery of services to individuals in the program.

Reports any operational, staff, or resident problems to the Residential Program Director.

Receives and accounts for client fees.

Develops effective working relationships with personnel from state and local agencies and families to coordinate the delivery of services to individuals in the program.

Insures that the facility is maintained in good condition and is operated in a safe, secure and lawful manner.

Controls home maintenance budget for the facility and petty cash fund, receives and accounts for client fees.

Assists clients in managing their personal income.

Conducts staff meetings, case conferences and in-service training programs.

Counsels residents regarding mental and emotional problems.

Responds appropriately to emergency situations.

Guides residents in the proper use of their civil rights.

## Required Knowledge, Skills and Abilities:

Thorough knowledge of the principles and methods of rehabilitation for the mentally retarded.

Thorough knowledge of normalization principle and ability to implement those principles.

Thorough knowledge of the principles and methods of casework as related to mental retardation.

Considerable knowledge of behavior management techniques, programs and principles.

Knowledge of mental retardation and its social and emotional impact on residents, families and the community.

Ability to plan and supervise the work of others.

Ability to establish and maintain effective working relationships.

Ability to communicate effectively.

Knowledgeable in the areas of programming, personnel, placement of residents, in-service training, budgets, residential standards and all other activities which are necessary in providing a comprehensive residential program for each individual client in the assigned Community Living Arrangements programs.

Ability to plan and supervise the following:

Goal Planning
Counseling
Service Coordination With Other Agencies

Conducts staff meetings, case conferences and in-service training programs.

Prepares various statistical and status reports as directed by the Residential Program Director.

Responds appropriately to emergency situations.

Performs related work as required.

Required Knowledges, Skills and Abilities: Knowledge of the principles and methods of rehabilitation for the program clients.

Knowledge of behavior management techniques, programs and principles.

Knowledge of applicable health and safety measures.

Knowledge of pertinent community resources and facilities.

Knowledge of the programs and objectives of base service units, community mental health centers, Children and Youth Agenencies, Agencies on the Aging, and other specialized county Human Services Programs.

Ability to plan, organize and direct the work of thers.

Ability to establish and maintain effective working relationships with county and state officials, clients and their families, and the general public.

Ability to exercise judgment and discretion in applying and interpreting laws, rules and policies governing county Human Services Residential Programs.

Ability to express ideas clearly and concisely, both orally and in writing.

Minimum Experience and Training: One year of experience as a Residential Program Worker.

or

Two years of experience in a Human Services Agency working with the mentally disabled, the elderly, or children and youth, including one year in a supervisory capacity.

or

Any equivalent combination of experience and training.

## The ALA Grant Advisory Committee's View of the Role and Functions of the Resident Advisor

Members of the ALA Advisory Committee (discussed in Chapter 2) were given a questionnaire to respond to the issue of Resident Advisor Roles and

Functions. Three questions related to Resident Advisor role and functions and are shown below with the Committee's responses.

Question One: "The way you see it, what is the functional role of the residential advisor (direct service person)?"

a. See that residents have basic needs cared for (e.g., nutrition, safety, grooming, etc.).

b. Train residents to care for basic needs (Activities of Daily Living).

c. Train residents in independent living skills (shopping, money management, telephone).

d. Provide emotional support to residents and monitor vocational progress.

e. Schedule medical psychological care as needed.

f. To provide a warm, nurturing environment that encourages growth.

g. To be a behavior specialist.

h. Provide professional level technical skills in the following areas:

    1. client contact, counselling, care management, programming.

    2. community contact, advocacy, public information, coordination of services.

    3. supervision, supervising colleagues, initiating, conducting peer conferences.

    4. Administration, recordkeeping, completion of required forms, scheduling.

i. Counselor, Teacher, Manager

j. To design and carry out individualized programs to prepare clients for functioning in society.

k. To help each client to develop skills necessary to achieve more independent living.

l. To encourage individual decision making, providing opportunity for individual to express his or her own interests, goals and concerns.

m. To counsel individuals regarding personal behavior, helping them to understand what is appropriate. Consistant sexuality education may be necessary to avoid behavior which has the potential of being socially dangerous and which may cause them to be removed to a more restricted environment.

n. To help individual utilize community resources (i.e. physician, dentist, MR Center, stores, library, recreation facilities, etc.).

o. To develop and implement programs (IPP's) based on ameliorating deficits in the adaptive behaviors in areas of personal management, social development, household management, and leisure time community activities.

p. To act as a role model and advisor.

q. To act as advocate insuring that other mandated services are provided.

r. Follow through on programs that require follow through in the residential setting.

s. CBTE developed in area of counseling.

t. To be able to identify resources in the community where residents can have their needs met.

u. How to do: Individual Program Planning, Nutrition, Sexuality, Safety.

v. Implementation and follow-up of programming to identify individual residents needs and to advocate these needs via usage of an assessment scale (PAC, FBS, BAS) and subsequent goal planning and/or behavior modification techniques.

w. Instruction in meal planning, comparative shopping, budgeting, laundry, cooking banking, good personal hygiene, good grooming, sexual education, proper cleaning of residences. Also usage of community facilities (e.g., recreational, specialty shops, public transportation, medical, etc.).

Question Two: What should the residential advisor's role be?

a. Function as an advocate for resident in acquiring services and improving services.

b. Be aggressive in guarding rights of residents.

c. Encourage and assist residents in socialization with the community.

d. Skills outlined in #1 on a more systematic, structured, informed basis.

e. Greater emphasis upon leadership which is encouraged and recognized.

f. Greater emphasis upon these functions as expectations as opposed to custodial caretaking functions.

Question Three: What are the 5 most important competencies a residential advisor should have?

a. Knowledge and understanding of the person with special needs.

b. Working knowledge of the theory of normalization.

c. Home management skills (to be a good model and instructor to residents).

d. Counseling skills.

e. Understanding of the system of service and the laws concerning services to the mentally retarded.

f. Able to make cogent, accurate observations.

g. Able to think through problem areas while maintaining a level of objectivity.

h. Have working understanding of behavior management and phenomenological techniques.

i. Able to efficiently structure time so that resident contact and documentation can both occur.

j. Able to identify realistic goals and structure an achievable process for accomplishing these goals.

k. Developmental programming with residents.

l. Human relations skills with professional colleagues and citizens in the community.

m. Developing individualized services for each resident.

n. Medical management.

o. Supervisor and conducting staff conferences

p. Interpersonal skills leading to helping people "become" (creating a therapeutic environment)

q. Individual program planning/implementation

r. Behavior management skills.

s. Business management skills.

t. Understanding of human development.

u. Translating assessment into program. Knowledge and skill in design and implementation of individual program plans.

v. Counseling skills--personal problems.

w. Teaching--appropriate behavior.

x. Teaching personal hygiene.

y. Knowledge and ability to do goal planning since no one really knows what works. Involve resident, focus on strengths, use of small steps, written documentation.

z. Understanding and willingness to communicate and be consistent.

aa. Understanding of some basic behavioral principles.

bb. Knowledge of basic counseling techniques and ability to give nonjudgemental feedback.

cc. Internalization of the philosophy of normalization.

dd. Ability to focus on the residents strengths.

ee. Maintain a positive attitude towards the residents capabilities of decreasing any negative behaviors.

ff. Ability to counsel or advise residents without assuming a parental role.

gg. Advocate for residents, whether problem is financial, medical, therapeutic, etc, in nature.

hh. Ability to work cooperatively with other resident advisors, so as to maximize services for the residents.

The salaries allowed under the above Commonwealth residential manpower class specifications are, as with the PACRP guidelines, subject to wide variation across the state. The actual salaries that are paid to resident advisors in practice is determined by the local County which administers the ALA programs. Currently the actual salaries paid to resident advisors may be as much as 25% lower than the maximum amount allowed. Table 2 shows the current allowable salary ranges approved by the Commonwealth.

TABLE 2

Salary Ranges Permitted Under the Commonwealth's Manpower Class Specifications for Residential Service Personnel

| Title | Salary Range |
|---|---|
| Residential Program Trainee (Direct Service Level 1) | $ 6,468- 9,264 |
| Residential Program Worker (Direct Service Level 2) | 7,520-10,182 |
| Residential Program Supervisor (Direct Service Level 3) | 7,720-11,162 |
| Residential Program Director I | 8,685-13,810 |
| Residential Program Director II | 10,954-15,902 |
| Residential Program Director III | 12,010-17,487 |

## Conclusion

The current state of the art in terms of ALA direct service manpower is characterized by change and nonuniformity. An appreciation of the tremendous variation which currently exists in the field can be had by noting the proliferation of labels used to describe ALA direct service manpower. Descriptive manpower labels used by ALA providers, trainers and state administrators include: resident advisor, resident counselor, house manager, housemother, housefather, foster parents, child care worker, resident supervisor, residential program worker, residential program supervisor, residential program aide, residential program trainee, residential services trainee, residential services worker, residential services supervisor ... ad infinitum. The myriad of manpower labels shown here are used to describe essentially only three direct service levels: resident advisors in training, trained resident advisors, and senior resident advisors who supervise trainees and other resident advisors. The process of definition which will free us from this mire of manpower labels must be entered upon by all those who have significant involvement in ALA services (i.e., consumers of service and/or advocates, direct service personnel, providers of service, appropriate state departments and personnel trainees). The definition process in ALA manpower must be guided by the answers to the following questions: a) Who is to be served? b) What are their service needs? and c) How are services to be delivered?

Clearly, responsibility of resident advisors are many. He or she must not only maintain a home (e.g., attend to housekeeping, meal planning/preparation, maintain a normalized home-like environment, etc.) but must also assist in the development and implementation of the ALA program, help design individual habilitation plans, provide guidance and counseling to program residents, supervise trainees, build rapport with neighbors and local providers of goods and services, process a myriad of paperwork involving program recordkeeping and reporting, etc. From the above, it should be apparent that the role of the resident advisor must be viewed as the major vehicle through which the needs of the ALA resident are expressed. Hence, it is essential that a person in such a critical role be highly trained and qualified. As a resident advisorship gains in "respectability," the resident advisor will take a place equal to other professionals involved in individual program planning (IPP, IEP, IHP) teams.

Given the already demanding nature of resident advisorship, the current movement to place significantly more impaired developmentally disabled persons in ALA settings (which the authors strongly endorse) will add to the responsibilities on the shoulder of the resident advisor and will require development of a high level of expertise on his or her part to meet the service needs presented by more severely impaired ALA residents. As will be shown in subsequent chapters, the skill areas and competencies required by resident advisors are far more numerous and complex than one might realize--except, of course, if you happen to be one of those who is performing this herculean task!

### Recommendations

1. Agreement on the part of direct service personnel, trainers, providers, and state administrators on the roles and functions of the three direct service manpower levels currently in practice throughout the Commonwealth (i.e., entry level resident advisor trainees, experienced resident advisors, and senior level resident advisor supervisors).

2. Establishment of uniform descriptive labels and the beginning of a systematic process to define the field of ALA manpower as a professional area with its own art and science.

3. Establishment of a state or national Professional Resident Advisor Association to assist in items 1 and 2 above and advocate for quality ALA services and betterment of the resident advisor's position in the community-based services system.

4. Development of standards for staff training.

5. Development of State Certification for trainees who complete approved training programs.

6. Establishment of preservice (A.A., B.A.) ALA direct service training programs throughout the Commonwealth which comply with established standards for training and certification.

7. Establishment of an information clearinghouse and communication network to disseminate information on ALA training materials, available training resources, research and evaluation. This organization can be centralized and/or regionalized within a state department, college, or university.

8. Funding support by appropriate state departments for preservice resident advisor training, research and program evaluation of all aspects of ALA services.

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## Chapter 4

# PERSPECTIVES FOR COMPETENCY INTERPRETATION AND UTILIZATION

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## INTRODUCTION

The competency approach to curriculum development was chosen because:

1. It was specific enough to provide direction for program developers, yet was flexible enough to be adopted by individuals with a variety of philosophical orientations in a multitude of settings.
2. It focused attention on the instructional needs of individual students with respect to descriptive outcomes without dictating the methodology of instruction.

In addition to the host of instructionally-based advantages to be described in the next section as benefits emanating from the competency approach, it was anticipated that a comprehensive listing of competencies indicative of the requirements placed on Resident Advisor (RA) trainees would:

1. Serve to dispel the myth that an RA's job was a simple, low level one which could adequately be filled by high school graduates without intensive service specific RA training.
2. Likely stimulate clarifying discussion among program developers as to which goals and competencies were most relevant and appropriate for their RA training program.
3. Assist individual program developers and instructors in generating instructional objectives for those competencies they agreed were most important.

Two central elements of the competency approach to curriculum development proposed herein are for individual program developers to analyze the competencies presented for relevance and utility in their own programs and to take those competencies judged most important a step further by formulating instructional objectives for them. Before proceeding, an examination of some of the differences between competencies and instructional objectives is in order.

Whereas both competencies and instructional objectives deal with behavior, or with observable events or outcomes, competencies are neither as behaviorally precise nor as criteria-specific as instructional objectives. A precise statement of criteria for evaluating performance is an essential defining element of an objective, but not of a competency. When competencies touch upon the evaluation of performance, it is usually done in a manner suggestive of an evaluation strategy. Rarely, if ever, do competencies provide standards of success which are as discernible and measurable as those provided by objectives. For example, a competency might read:

> Identify salient factors commonly inhibiting the free sharing of information and opinions in small group interdisciplinary program planning meetings.

The word "identify" is suggestive of an evaluation strategy. However, it is not clear what the trainee would have to do to demonstrate competence. The competency statement lacks the precise performance to be evidenced, the criteria for success, and the conditions or givens under which the specified behavior is expected to occur. To translate the competency into an instructional objective fully conforming to Mager's (1975) specifications of performance, criteria, and conditions, it is necessary to:

1. Choose the most appropriate behavior (performance) from the numerous actions that might appropriately represent "identify." In this instance, it might be "sort into two piles."

2. Establish and include criteria in the objective. In this instance, assume that "with 80% accuracy" constitutes a valid criterion.

3. State the conditions under which the student would "sort into two piles with 80% accuracy." A condition might be "Given 30 index cards with statements describing salient factors which are likely or unlikely to inhibit the free sharing of information and opinions in small group interdisciplinary program planning meetings . . ."

The instructional objective would then read:

> Given 30 index cards with statements describing factors which are likely or unlikely to inhibit the free sharing of information and opinions in small group interdisciplinary program planning meetings, sort the statements into inhibiting and non-inhibiting piles with a minimum of 80% accuracy.

In sum, competencies are often behaviorally less precise (e.g., "identify" versus "sort. . . into inhibiting and non-inhibiting piles") than are instructional objectives and do not contain precise criterion statements, which are defining elements for objectives. After reviewing the competencies contained in this document the reader may notice that whenever possible conditions have been specified. As a rule, conditions should be stated when their inclusion is feasible and when they make the intent of a competency more explicit.

There are potential advantages of considerable import for both program development and implementation to be gained by transforming competencies into instructional objectives. This is especially so when the instructional objectives are developed by those professionals intimately involved in the training program and are systematically reviewed and/or revised by the professional staff, by peer groups within and external to the institution, and by others essential to the future of the program, who desire to be involved at this level. Potential advantages of instructional objectives emanating from this process include, but are not limited to:

1. Their being more sensitive to and reflective of unique but often difficult to observe program factors critical to the successful implementation of curricula. These factors include the specific orientation, structure, and resources of the program as well as the individual characteristics of the faculty and student body and the employment demands made of graduates.

2. Their affording significant parties the opportunity to negotiate for meaning, to challenge abstractions, and to clarify intent while formulating individual objectives. Such interaction should result in the use of descriptive words and phrases which are highly resistant to speculation and misinterpretation.

3. Their being far more complete and specific, heightening the degree to which intent can accurately be communicated to significantly involved individuals.

The author reasons that the overall effect of transforming competencies into program-specific and program-sensitive instructional objectives is to increase the probability of more relevant, focused, and responsive instruction. From the process represented in Figure 1 it should be clear that the author has divorced himself from the traditional realm of the static "this is it" structure of curricula and has conceptualized a Product-Process Competency Approach (PPCA) in which a product (set of competencies) provides the structure and direction for a process (e.g., competency selection, modification and development; instructional objectives development; evaluation and adjustment) that will lead to individualized curricula in different training programs. In addition to the reasons already given for individual programs to develop instructional objectives of their own, such a combined product-process competency approach is advocated because:

1. It is neither possible nor desirable to impose a packaged curriculum on a group of well-trained professionals who are aware of the subtle forces influencing the structure, character, quality and goals of programs within the unique social, political, and educational context in which they function.

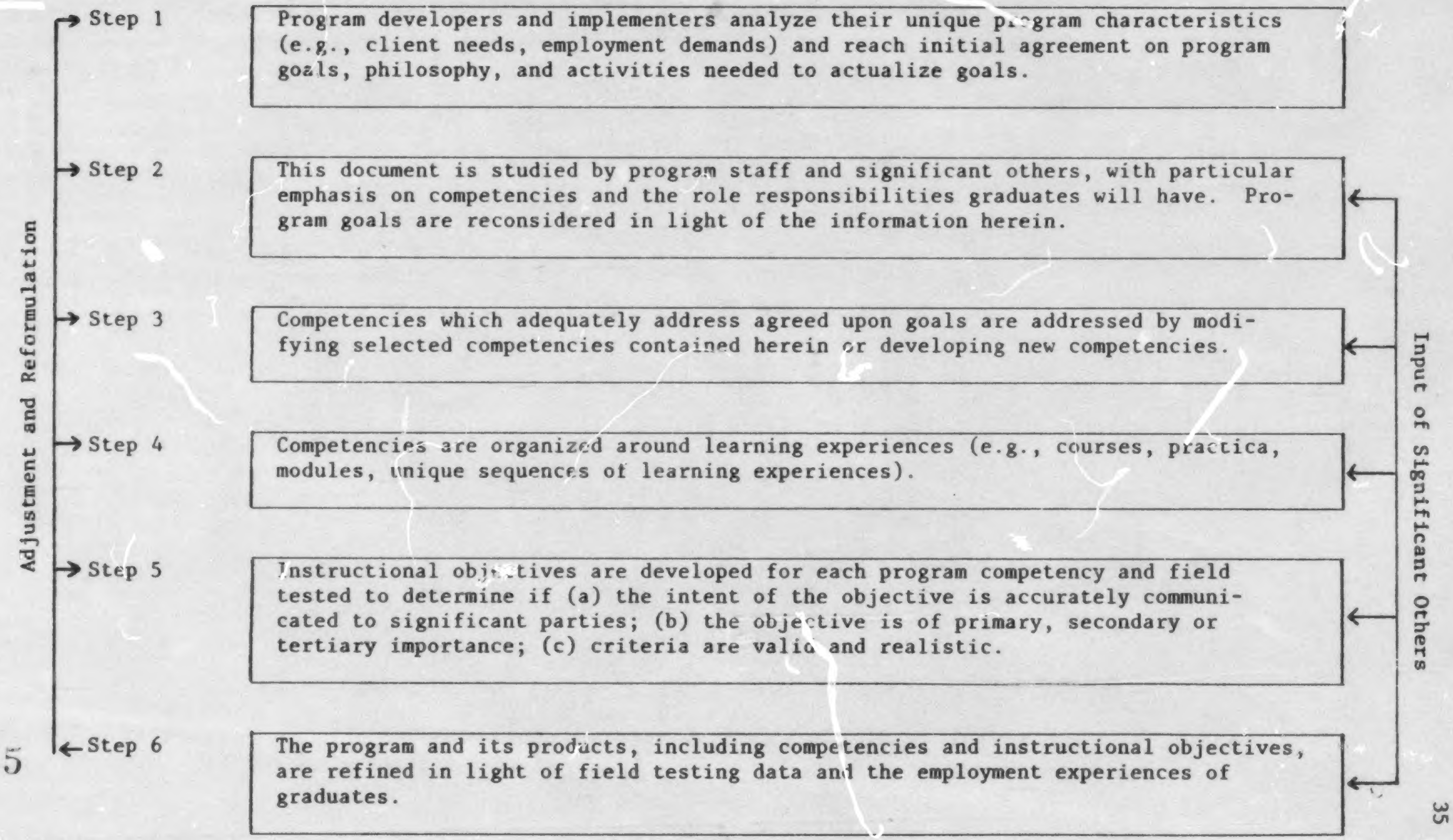
2. Pre-packaged materials are not sensitive to the changing needs of students, which influence both competencies and objectives and influence the nature of instruction. As experienced instructors know, student needs change not only from year to year but within semesters.

3. Experience suggests that highly trained individuals, used to thinking for themselves, will reformulate materials to fit their own needs, regardless of the "cohesiveness" or "packaging" of the materials.

4. The likelihood of a firm commitment to implementation increases as one feels more influential in developing an idea or program.

Figure 1

The Product-Process Competency Approach (PPCA)[1]



Step 1 — Program developers and implementers analyze their unique program characteristics (e.g., client needs, employment demands) and reach initial agreement on program goals, philosophy, and activities needed to actualize goals.

Step 2 — This document is studied by program staff and significant others, with particular emphasis on competencies and the role responsibilities graduates will have. Program goals are reconsidered in light of the information herein.

Step 3 — Competencies which adequately address agreed upon goals are addressed by modifying selected competencies contained herein or developing new competencies.

Step 4 — Competencies are organized around learning experiences (e.g., courses, practica, modules, unique sequences of learning experiences).

Step 5 — Instructional objectives are developed for each program competency and field tested to determine if (a) the intent of the objective is accurately communicated to significant parties; (b) the objective is of primary, secondary or tertiary importance; (c) criteria are valid and realistic.

Step 6 — The program and its products, including competencies and instructional objectives, are refined in light of field testing data and the employment experiences of graduates.

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[1] See Houston (1974) for a compatible model.

> Simply being convinced that an idea or program is worthy does not elicit nearly as high a degree of commitment to its successful actualization as does actively contributing to its conceptualization and development (Johnson & Johnson, 1975).

Before reviewing Figure 1, the reader should be aware that a goal differs substantially from both a competency and an objective. The term goal refers to a broader, more abstract idea. Usually it is easier to reach agreement on goals than on competencies; likewise, it is easier to reach agreement on competencies than on objectives. The reason for this trend is that the more precise and concrete one becomes, the more obvious are the differences among people, which were heretofore concealed by abstract statements. Abstraction allows one to freely attribute to a statement whatever he wishes; consequently, the greater the degree of abstraction, the greater the unrecognized disagreement or misunderstanding is likely to be. If goals were perfectly clear, the vast majority of parties would likely agree on the performance satisfying goal attainment, thus negating the need to move from goals to competencies to objectives. Pragmatically, however, clarity and the abstraction which characterizes goals are antagonistic, requiring the movement from goals to objectives so that involved parties have a true idea and accurate grasp of that which is actually being communicated. It is at this last level, the concrete level of objectives, that differences of opinion and understanding are accurately identified and isolated, and that maximal opportunity for true understanding and agreement exists. In discussing conflict resolution, which is progressively analogous to reaching agreement on goals, competencies and especially objectives, Johnson and Johnson (1975) stress:

> Different positions need to be clearly understood before successful compromises and integrations of positions can be made . . . . The potential for integration is never greater than the adequacy of the differentiation already achieved (p. 199).

The use of the phrase "significant others" in Step 2 of Figure 1 should be noted. "Significant others" refers to anyone who is sincerely interested in furthering the aims of the program and can make a positive contribution. More importantly, it refers to those in positions to directly further or impede the goals of the program, such as ALA supervisors, government administrators, program directors, RAs, union leaders, and university officials. To reasonably involve these persons during the formative stages in a manner they find satisfying, is essential; to ignore them is to invite disaster. Thus, the author's support Houston's (1974) admonition that:

> Not everybody wants to design the program. Some only want to be apprised of progress or to be involved in basic decisions . . . . But everybody wants to be informed. Those who are not informed tend to be negative about the process and the results (p. 29).

This negativism may well take the form of anger and the needless creation of obstacles inimical to progress.

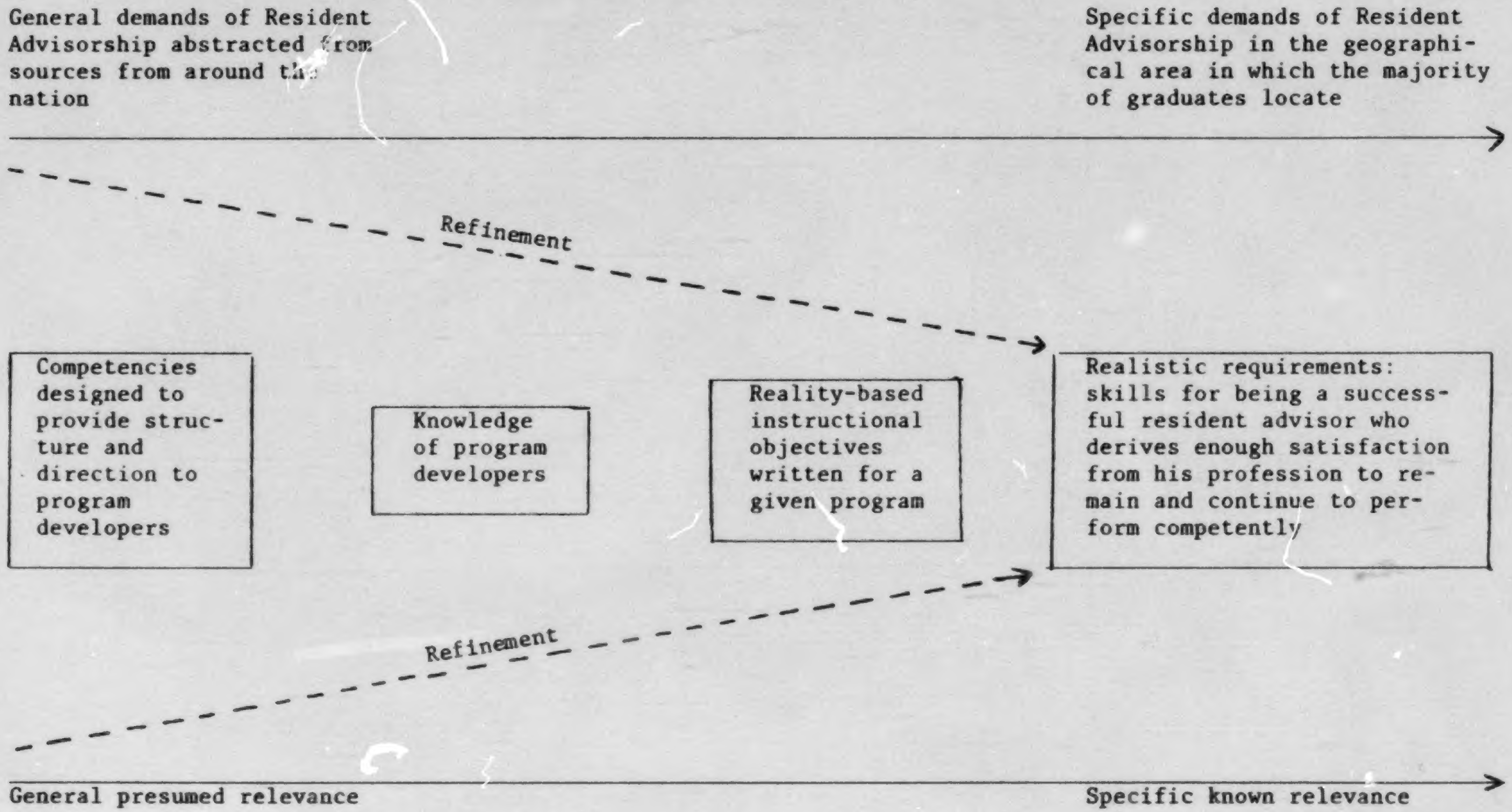
Some may argue that outside parties should be involved in the very first stage, and perhaps they are right. The experience of the author, however, suggests that time for quiet contemplation, free from the sustained involvement of significant others is needed to develop an initial, rationally connected set of clearly stated goals, a coherent philosophy, and a realistic assessment of the resources and events needed for actualizing the goals. Once clarity in these areas is achieved, it is far more likely that the rationale presented by program developers to potentially significant parties will be sound, well-articulated, and convincing. Equally important is that program staff will then be able to identify similarities and differences in their positions and those of others, and to reach agreement, compromise or consensus from the vantage point of understanding rather than political and administrative exigency. None of this negates the serious consideration program developers should give to the input of significant others in steps two through six. And where warranted by the input, the program should be modified accordingly. Similarly, having a clearly articulated and fully developed conceptualization of the program during the formative stages, without blind allegiance to its immutability allows one to deal more realistically, logically, and competently with the contributions and needs of others. When modifications or improvements are made on the suggestion of others or when others see that decisions are rationally rather than emotionally arrived at, it is most likely that they will develop an even greater commitment to the success of the program. For rational, unbiased, and objective thinking and decision making to characterize steps two through six, thorough knowledge of the goals, philosophy, and activities of the program sought in Step 1 is required. Again it should be emphasized that what is achieved in Step 1 is not abiding, but is subject to change based on the quality of additional input in subsequent stages.

A second way of conceptualizing the movement from competencies to instructional objectives is to consider it as a quest for refinement, resulting in increased relevance or focus. Such movement will more adequately direct instruction to those aspects of a generalized curriculum most important to a particular program during a particular period of time, in a way that takes into account student differences and the external system (e.g., client needs, employment demands) to which a program must satisfactorily respond to be worthwhile and effective. Consider the direction of movement, the narrowing of focus and the concomitant increase in relevance diagrammed in Figure 2.

It should be noted that refinement can take at least two forms. The first is selecting competencies relevant to a particular program. The second is formulating instructional objectives. If all the competencies in a particular cluster of competencies (e.g., Behavior Change) are considered relevant to the immediate needs of a program, then all should be used to assist in the formulation of instructional objectives for the program. If only some are designated as relevant, then only those should be used.

Figure 2

Conceptualization of the Refinement Process


General demands of Resident Advisorship abstracted from sources from around the nation
Specific demands of Resident Advisorship in the geographical area in which the majority of graduates locate
Refinement
Competencies designed to provide structure and direction to program developers
Knowledge of program developers
Reality-based instructional objectives written for a given program
Realistic requirements: skills for being a successful resident advisor who derives enough satisfaction from his profession to remain and continue to perform competently
Refinement
General presumed relevance
Specific known relevance

As previously discussed, a primary distinction between competencies and instructional objectives lies in the level of comprehensiveness. Without knowing the exact circumstances or context in which instruction will occur, one is limited to developing competencies which are behaviorally oriented directional statements designed to focus thought. By necessity competencies are frequently devoid of conditions and almost always devoid of specific criteria. Knowing the context of instruction and being aware of the pertinent variables affecting the nature of instruction and evaluation allows one to move forward in specifying the exact behaviors to be executed, the conditions under which they should be performed, and the criteria for satisfactory achievement. Not knowing such facts as the opportunities available for students to obtain relevant experiences and express competence, the academic abilities of the students, and the availability of assessment materials, precludes developing instructional objectives which adhere to Mager's (1975) three elements of performance, criteria, and conditions. This diminishes the potential for accurately communicating instructional intent. This does not mean, however, that competency documents such as this, which are designed for general distribution and cannot respond to those variables which inevitably dictate the nature of particular programs, are not of direct and immediate value. Competencies act as catalysts by providing structure and direction which facilitates the development of more precise objectives. They begin identifying those cognitive and psychomotor elements of behavior and those specifics of knowledge which should be considered or emphasized when developing programs and provide ideas suggestive of how an individual's level of mastery should be assessed. The intermediate level of abstraction characteristic of competencies, relative to goals and instructional objectives, should compel those attracted to competencies and behavioral specificity to closely examine their particular programs and to develop curricula consistent with those forces which guide the program and which ultimately are responsible for its success.

It should be noted that although the competency approach was judged superior to other curriculum development approaches for training RAs, it is not without potentially significant limitations. The strengths and potential limitations of the PPCA and a more detailed treatment of the manner in which the competencies in this document might best be utilized will be considered throughout this chapter. It should be realized that what is presented for training RAs is an *initial step* in the systematic development of curricula for a newly emerging profession in a state of rapid transition. Cognizance of the need for such an effort grew out of the recent realization that the responsibility of training RAs is *more complex* and *more demanding* and perhaps even *more important* than was previously thought.

As a new approach to training RAs, the PPCA should be carefully analyzed, criticized, and tested by those contemplating training programs in this area, so that future curricula will reflect thoughtful progress. On the other hand, it should not be arbitrarily rejected on an emotional level because a particular element of the approach rubs an ingrained bias or two the wrong way. As in all initial efforts to train those preparing for the helping professions, it will become obvious that there is much to learn. This is a beginning.

## THE PRODUCT-PROCESS COMPETENCY APPROACH: STRENGTHS

Blackhurst (1978) has identified seven major characteristics of an ideal competency-based training program for professionals:

1. Competencies are publicly stated.
2. Objectives for learners are identified in behavioral terms.
3. Criteria for measuring competencies are specified.
4. Alternative learning activities are made available to students.
5. Time for reaching competence is variable while achievement is held constant.
6. Teachers are held accountable for program design while students are accountable for their own achievements.
7. Programs are individualized.

In addition, the transformation of competencies into clearly stated instructional objectives which communicate basic intents should:

8. Reduce misconceptions and misinterpretation and thus antagonism among parties involved in training.
9. Provide firm ground for judging the importance of competencies and objectives so that "trite" competencies and objectives are easily recognized and discarded.
10. Assist instructors in choosing methods and materials for instruction.
11. Provide guidance for developing evaluation instruments and strategies reflecting the basic intents of instruction.
12. Assist instructors in rapidly evaluating the status of individual students relative to specific competencies at a given moment and in isolating areas needing immediate instructional focus.
13. Afford students opportunities for gauging their progress so they can marshal their resources to meet instructional goals independent of instructor efforts.
14. Eliminate the need for students to waste inordinate amounts of time and energy in "psyching-out" instructors by identifying what is "really" wanted.
15. Reduce instructional redundancy by eliminating involvement in areas where mastery has been demonstrated and focusing on areas in which criterion performance has yet to be achieved.

16. Provide instructors and administrators with information needed for maximizing the articulation of educational experiences, e.g., eliminating instructional redundancy, addressing experiential gaps, matching practicum experiences with classroom content.

While the benefits enumerated above are impressive, they are not automatically achieved by simply delineating sets of competencies and corresponding objectives. A careful delineation of essential competencies is an initial step necessary for developing superior competency-based professional preparation programs--but by itself it is not sufficient. Perspective for viewing the rate of expected program progress is gained from Blackhurst's (1978) experiences directing what is reputed to be one of the more advanced competency-based programs for the preparation of special education teachers:

> At our present state of development, it is important to view our efforts as approximations to an ideal CBTE [Competency Based Teacher Education] program. It will probably take years if not decades, to develop a complete program that fully meets all of the characteristics advocated by proponents of this approach (p. 225).

## THE PRODUCT-PROCESS COMPETENCY APPROACH: LIMITATIONS AND CONSIDERATIONS

Every curriculum development approach has both actual and potential limitations. When one is unaware of these limitations, he may adhere to false assumptions and perpetuate poor practices. The purpose of this section is to point out and discuss some of the actual and potential limitations of the approach and to clear up some possible misunderstandings about what constitutes the competency approach to curriculum development advocated herein. Awareness of potential difficulties and practices should assist program developers and instructors in avoiding methods and thought patterns which are likely to prove counterproductive. Thus the following limitations and considerations need to be kept in mind:

1. The competencies contained herein have content validity, but still need to be empirically validated.

As relatively few moderately to profoundly developmentally disabled individuals needing direct care or supervision have lived in Alternative Living Arrangements (ALAs) for protracted periods of time (e.g., several years), and as there are so few established, preservice, degree granting training programs (Fiorelli, Heverly & Conroy, 1979) specifically designed to prepare RAs for direct service professional roles, the competencies listed herein are based primarily on expert judgments. The competencies have content validity in that they were developed and reviewed by RAs and other professionals reputed to be highly involved and knowledgeable in the areas of ALA direct service programming, administration, and the short-term inservice training of RAs. This, however is not a substitute for the empirical validation of competencies.

Although most unlikely, it is conceivable that during training an individual may reach criterion for achievement on each instructional objective emanating from those competencies judged important, and yet perform inadequately as an RA. In part, this may be attributed to the complexity of man; to our less than complete understanding of ALAs, developmental disabilities, normalization, and the reasons people perform at less than capacity; and to the ever changing influences on people's lives. Empirically, it necessitates systematically evaluating the predictive validity of the competency approach for training RAs, from the perspective of individual competencies and competency clusters, as well as from the perspective of the entire approach. Validation should consider particular professional functions and situations and should emphasize the effects of RA functioning on residents.

2. Competencies and their corresponding instructional objectives are both data points which often represent broader constructs and statements alluding to behaviors that are of direct and immediate importance in their own right.

Ojemann (1974) captured the essence of the need for competencies and instructional objectives when he wrote:

> Changes in the learner--changes in the learner's concepts, skills, attitudes, and emotional patterns - are internal. One cannot see inside a pupil to find out whether he has acquired a given skill, knowledge of a principle, or a specified emotional pattern. The problem is how to make communication about non-observables meaningful . . . . The use of behavioral referents is the only method for making communication about non-observables meaningful that has been found so far (pp. 294-295).

This suggests that a competency and its instructional objective(s) may justifiably be viewed as data points and not as complete, totally reliable reflections of underlying attributes or understandings. In other words, competencies and objectives may be indicative of far more than that which is required of the trainees. Examine, for example, the instructional objective:

> Given 30 index cards with statements describing factors which are likely or unlikely to inhibit the free sharing of information and opinions in small group interdisciplinary program planning meetings, sort the statements into inhibiting and non-inhibiting piles with a minimum of 80% accuracy.

In the mind of the program developer, successful performance by the trainee on the instructional objective may represent that which the developer is willing to accept to affirm that the individual is sufficiently knowledgeable about factors which influence the exchange of ideas in interdisciplinary program planning groups. It should be noted, however, that other programs may require more extensive evidence or evidence of a different variety to satisfy their criteria for sufficient knowledge.

The preceding should not be interpreted to mean that competencies and corresponding objectives should be viewed solely as data points devoid of intrinsic or independent value. Just the opposite. While competencies and instructional objectives may profitably be viewed as data points for representing competence in a universe of almost infinite possibilities, competencies and objectives should be selected primarily because what they require of the trainee is important for its own sake. Reaching criterion on an instructional objective should satisfy professional observers that what the trainee has mastered has direct and immediate value to his development as a skilled and knowledgeable professional. There should be direct and immediate value for the trainee's professional development in being able to isolate factors inhibiting the free sharing of information in small groups from factors not likely to have such an effect. Professionals should be able to identify these factors and such knowledge or its absence should influence their effectiveness. In sum, although a competency or an instructional objective may represent a broader and perhaps more involved concept, in the narrow sense the behavior required of the trainee should be important in its own right, and achieving criteria should be a direct measure that the trainee has mastered an important concept or has attained an important skill which professionals should possess.

3. To varying degrees, both competencies and instructional objectives may be subject to the potential limitations of language and thus misinterpretation, necessitating measures to standardize the meaning of language or strategies for developing common frames of reference for interpretating key words containing elements of abstraction.

As noted previously, individual programs will need to formulate instructional objectives for those competencies significantly involved parties agree should receive emphasis. In some instances, however, even instructional objectives may contain some undesirable traces of vagueness and imprecision, especially when they deal with the affective domain or some of the higher level cognitive skills. This may be a function of the limitations of language and the limitations of one-way communication. As Katz (1974) has observed, "[language] is a very limited device for producing common understanding when there is no basis in common experience (p. 251)." Analogously, to the extent individual experiences differ, communication may be impeded. These experiential differences may be subtle, but their effects relative to common understanding and interpretation may be powerful. In other words, what may be clear to the writer of an instructional objective and those who initially review it may, at a later date, contain elements of abstraction subject to misinterpretation by newly involved parties.

The written word represents a one-way communication pattern which has the lowest potential of all communication patterns for achieving common understanding. Such a communication pattern does not allow receivers (e.g., readers) to ask senders (e.g., writers) clarifying questions. According to Johnson and Johnson (1975), such situations are satisfying to message senders who typically assume their messages are clear, but are often acutely frustrating to message receivers, who knowingly or unknowingly fail to grasp the complete meaning and significance of the message. What is needed in instances where it is likely that words will eventually lack the requisite specificity and commonality of definition and connotation requisite for congruous understanding is ample opportunity for senders and receivers to define the words or ideas in question and negotiate for meaning.

The concept of "respect" is an example of a word that is highly susceptible to variant interpretations over time. It represents an extremely relative, vague, and abstract concept referring to a class of actions that is highly bound to one's culture and personal experiences. In addition, the definition a particular individual gives to the word may differ over time as he and the situations he is involved in change. Opportunities to define the term and negotiate for meaning (i.e., identify how interpretations differ and reach agreement on a common definition) should take the shape of posing questions and asking for a reduction of "respect" to the more concrete level of discrete behavioral elements. This may result in the instructor providing a definition, or the group formulating a definition, taking the form: "intently listening to the resident; paraphrasing the resident's messages and asking him to evaluate the accuracy of the paraphrasing; asking for the resident's opinions; maintaining eye contact for the majority of the interaction; allowing the resident to make choices; being supportive when the opportunity presents itself; when disagreeing, focusing on ideas without allowing the conversation to degenerate into an assault on personality." Yet even this is a verbal symbolic representation subject to misinterpretation and speculation because of the limitations of language. Words such as "intently" and "supportive" need further clarification as does the description of those situations in which the resident should be allowed to make choices. As program staff develop and significant parties change (e.g., students, practicum site personnel) further concretizing may be necessary. Mager's (1977) small volume on "Goal Analysis" provides an excellent, structured strategy for dealing with these difficulties by substantially reducing and in some cases eliminating abstraction and confusion when developing competencies and objectives.

In brief, Mager (1977) suggests that goal analysis proceed in the following manner:

a. Write the goal down on paper without worrying about how vague or abstract it is.

b. Write down the things that someone should say or do that would provide you with adequate evidence he had achieved the goal. Abstraction or vagueness should not be of concern at this point. If there is difficulty in identifying performances that would satisfy the goal, ask:

    (1) What would a person be doing that would cause me to say he has achieved the goal?

    (2) Given a room full of students, what is the basis on which I would separate them into two piles, those who have achieved the goal and those who have not?

    (3) How would I recognize goal achievement when I saw it?

    (4) Who is someone who exemplifies achieving the goal? What does he say or do that makes me willing to say he is an outstanding example of having achieved the goal?

c. Look over the list of performances and cross out duplications and things that no longer belong. If something is still fuzzy or vague, put it on a separate sheet for further analysis in accordance with the entire procedure outlined in this section.

d. Write a complete statement for each performance describing the nature, quality, or amount considered acceptable (e.g., "Reads regularly" may be transformed into "Without prompting or pressure, he voluntarily selects a book of his choice and reads it for at least a half-hour every day").

e. Test the statements with the question, "If someone achieved or demonstrated each of the performances, would I be willing to say he has achieved the goal?" An affirmative answer indicates the analysis is finished; a negative response indicates the statements need to be modified.

Another way to begin arriving at common definition and understanding is to move away from isolated words, phrases and statements, toward scripted or unrehearsed, reality-based action. The instructor may demonstrate "respect" or the lack of it in a variety of role-playing situations. Having real or scripted examples of typical behaviors which fall under the rubrics of "respect" and "disrespect" on videotape readily available to students and others involved with the objective may prove an even more valuable contribution to the standardization of meaning over time. Discussion, a valuable colateral activity following modeling situations, should then focus on the precise behavioral elements of both constructs, so that more definite, reality-based operationalizations or parameters evolve from the observations. Again, Mager's (1977) book, "Goal Analysis," should prove of significant value in defining the behavioral elements of abstract concepts such as "respect" in both live and videotaped situations.

What has been discussed regarding language in this section is just as much a reflection of the natural idiosyncracy of thought as it is an indication of the natural, though often subtle, idiosyncracy of language. Because two interpretations of a statement differ does not automatically suggest that they be prioritized in terms of correctness and value. Rather the occurrence might profitably be viewed as a natural consequence of two or more individuals dealing with the same issues. More importantly, it suggests that the task before the disagreeing parties is to reach a common understanding so they can effectively communicate with each other. Note that the emphasis is not on a universal meaning, but on a common meaning among currently involved parties so that words, phrases, and statements will be clear and to the point for those involved or interested in the program. Without common meaning, misunderstanding is inevitable. Attendant to misunderstanding is usually some degree of surprise, disappointment, conflict, and enmity, which no program needs.

4. Competencies and instructional objectives focus exclusively on the parts, ignoring the importance and integrity of the whole, resulting in fragmented learning. Moreover, the competency and objectives approach to curriculum development allows only for

the didactic transfer of information and is antagnostic to heuristic or philetic instruction, which in the long run, may be of greatest importance.

Broudy's (cited in Pottinger, 1976) criticisms of Performance [or Competency] Based Teacher Education (PBTE) are of distinct importance to those considering using competencies or instructional objectives as core elements in the training of RAs. Broudy wrote:

> The belief that the whole is merely the sum of its parts is a notoriously inadequate description of any human action, let alone one so complex as teaching. Teaching can, of course, be thought of as broken down into parts, but as a concrete action it is guided at every moment by a sense of its total pattern. This pattern--in swimming, reading, classifying, judging --integrates the analyzed constituents into a meaningful functional sequence, not merely a mechanical additive one. We are told, at least by some psychologists, that after the pattern has been sensed or felt or understood, the details can be perfected seperately, but until the pattern has been discerned, drilling on the separate parts yields disappointing results (p. 34).
>
> Didactics refers to the impartation of knowledge by the teacher to the pupil; heuristics refers to the effort to help the pupil discover for himself either the contents of a body of knowledge or the methods of arriving at such knowledge and assessing it; philetics is merely a Greek name for love or securing rapport with pupils or, as the current jargon has it, 'relating to pupils' . . . . Performance based programs can accommodate didactics, which aims at more or less rote mastery of a repertoire or explicitly formulated knowledge and skill. Heuristic and philetic teaching do not lend themselves to the precise analysis, specification, and evaluation . . . of PBTE . . . . Success in heuristic and philetic teaching cannot be judged by prespecified appropriate pupil behavior because such behavior--even when we can identify it--is not manifested on demand or at at specific time. Critical thinking, the use of the imagination, warm feeling toward peers, achievement of identity cannot be inferred from one segment of behavior used as a test pattern (pp. 34-35).

The foregoing was not cited for purposes of self-flagellation. Rather, it was presented to illustrate some of the possible, but not inevitable, limitations of the competency approach. What follows is an attempt to address these criticisms.

Broudy's concerns are warranted. It is far too easy for a program to become a sterile experience by only emphasizing readily measured, isolated parts of broader concepts which gain their full meaning by being elements of larger, more complicated and articulated networks of ideas, while forgetting that the process of instruction is as important as the product and that some of the more important lasting results of instruction may not be obvious or measurable during a student's involvement in a program. This is not a deficiency of competencies or instructional objectives per se, but a function of the narrowness of program conceptualization or the mistaken belief that highly reliable measurement is the sole criterion for relevancy. All activities need not narrowly relate to prespecified competencies and objectives, and in all probability they will not, at least not in creative programs which are responsive to the suddenly shifting needs of students and residents. But it is the framework of competencies and instructional objectives which provides the major thrust for content emphasis, program direction, and minimal standards of student performance. In this instance, minimal is not tantamount to inadequate nor to Broudy's "rote mastery", but refers to the lower levels of adequate or satisfactory performance. And although facts need to be memorized, neither competencies nor objectives need to be restricted to engaging lower level thought processes, such as recall and summation. An ample number of competencies should require these two rudimentary processes, and many should elicit such activities as introspection and the engagement of higher level cognitive processes, including prediction, evaluation, and the application of knowledge to developing solutions to a variety of important problems likely to be encountered in the world of the RA. Accordingly, competencies such as the following, which are likely to encourage high level, integrative thought patterns, generalizable to an infinite number of ALA situations, should play prominent roles in the curriculum:

a. Behavior Change

Develop a case study of a resident who exhibited severe behavior and/or learning problems before treatment. Clearly delineate:

(1) the nature of the problem(s)
(2) probable causation
(3) the treatment objectives
(4) the treatment provided
(5) the results obtained
(6) recommendations for the future

Provide substantiating evidence for sections 1, 2, 3 and elsewhere, where warranted.

b. Case Management

Identify and describe the basic difficulties a group is having communicating effectively, cite the reasons for the difficulties, and devise ameliorative strategies which should substantially lessen the difficulties, given a specific case management group to observe.

c. Definition and Causes

Explain what is meant by the concept that many exceptionalities or components of deviance are transitory and specify the implications of this concept for individual program planning (e.g. the verbal aggressiveness of a cerebral palsied adult may be transitory, but his involuntary motor movements are likely to be permanent).

d. Instructional Analysis

Teach a resident how to perform a complex task that is new to him by:

(1) analyzing the task into components which the resident can do,

(2) having the resident sequentially integrate all the components into a whole, and

(3) having the resident perform the task three consecutive times without error.

e. Normalization

Write an individual habilitation plan for re-integrating an institutionalized resident into the community, given specific diagnostic data and a case history. The plan should specify how appropriate community resources (e.g., businesses, rehabilatation agencies) should be involved and how progress will be evaluated.

f. Orientation to Service Population

Define motivation and explain its development and maintenance with reference to a particular client.

g. Individual Program Design, Implementation and Evaluation

List three possible dangers of involving a resident and/or his parents in an individual program planning meeting and provide strategies for eliminating or substantially reducing these dangers.

Intuitively, Broudy's position that "success in heuristic and philetic teaching cannot be judged by prespecified appropriate pupil behavior because such behavior . . . . is not manifested on demand at a specific time" (p. 38) conveys the ring of truth and importance. Assuming, however, that a program is well organized (e.g., competencies and corresponding objectives have been developed by highly experienced practitioners and educators, blending the "real world" of practica with the more longitudinal, theoretical concerns of academicians) it is unlikely that an individual failing to reach criteria on the central objectives of that program will suddenly be able to function successfully when employed in an ALA.

This is not to deny the legitmacy of Broudy's position, but to provide perspective. It is to indicate that although individuals should be *selectively encouraged* to go beyond the minimal content and expectations of an RA training program, in a profession where a resident's life may depend upon adequate RA training, realistic and well focused state-of-the-art standards should be adhered to (and improved, through evaluation and research) as a minimal requisite core. In a similar vein, Broudy is correct when he argues that we cannot anticipate all appropriate responses. The student, however, should be able to adequately express those *minimal prespecified* behaviors designed to provide evidence of competence in areas deemed important to RA success. In the unlikely event that a student projects an "aura" of competence, yet cannot meet the damands of individual instructional objectives, both he and the objectives in question should be re-evaluated to identify the source(s) of difficulty.

5. *The Product-Process Competency Approach requires a greater investment of time, energy and thought on the part of program developers and staff than more traditionally structured curriculum packages which are designed to be implemented "as is."*

There is little doubt that the PPCA requires a greater investment of time, energy, and thought on the part of all involved than would a more traditionally structured curriculum approach presenting a finalized package. This additional investment becomes obvious in the activities referenced below, which are time consuming compared to the idea of a packaged program. Yet each of these activities has intrinsic value that substantially enhances a program's viability by enhancing its responsiveness to the needs of residents, trainees, and the community. Such responsiveness and concern for noncurricular factors influencing a program's development engenders both the community and institutional support needed for establishing a comprehensive training program designed to prepare RAs to function effectively in the community.

Actively involving those who can effect a program's future by keeping them informed and inviting them to contribute to the development of overall program goals, the selection of competencies, the formulation of objectives, and the design of the instructional portion of a program markedly increases the probability that the program will be sufficiently reflective of reality, will receive the necessary support and involvement of influential parties at critical junctures, and will not suddenly be thwarted by unexpected political and philosophical differences. Just as pragmatic is the increased likelihood that such widespread involvement will provide needed information of a professional nature and raise essential questions almost inevitably overlooked by those most closely involved in developing the program. In a similar vein, the development of the competency and objective components of the program by its developers in the context of external involvement will likely compel developers to examine their actions with greater care and attention to both the program's overall goals and immediate details. This, like the solicited involvement of external parties, should invoke an increasing sense of ownership and commitment and contribute to improving the quality of the program.

Instituting systematic evaluations of program appropriateness and effectiveness and establishing a visible, potent, and responsive adjustment mechanism for responsibly dealing with the data from program evaluations is necessary for reducing opposition to new programs and ideas and for smoothly inaugurating program modifications suggested by evaluative data. Such an adjustment mechanism, considered an integral part of the PPCA, most likely reduces opposition by addressing one of the primary sources of resistance to change: the belief that once change occurs it becomes permanent, regardless of subsequent findings.

An excellent model of an effective adjustment mechanism is an advisory board, consisting of high level administrative personnel and a cross-section of interested faculty from the sponsoring institution and influential parties from concerned portions of the community. For such a mechanism to work and to be more than an insipid group limited to going through "the motions" demands a considerable investment of time and effort on the part of staff. It requires open lines of communication, periodic meetings revolving around substantive issues, ongoing evaluations of program effectiveness, and attention to the many details of group maintenance. A well-conceived adjustment mechanism, such as an advisory board, can contribute substantially to improving the quality of training by helping to make necessary program modifications. A concomitant gain for all involved are the positive motivational effects derived from the realizations that honest attempts will be made to modify the program in light of objectively obtained evaluative data and that there is a stable mechanism in place (i.e., the advisory board) to facilitate such modification. Hence, like other parts of the PPCA, the time invested contains the potential for developing superior training programs which are continuously sensitive and responsive to the needs of staff, trainees, and most importantly, the residents the program is designed to ultimately serve. The central point to be derived from this section is that although the PPCA is more complex and demanding than fully packaged programs, each of the components serves the vital function of making the training program as relevant, excellent, and viable as possible.

6. In the final analysis, behavioral objectives cannot deal with affect. This seriously limits the capacity of an objectives-oriented curriculum for dealing with the professional development of the total individual, which must include affective as well as cognitive concerns.

Mager (1977) provides some apparently simple yet highly insightful answers to the question, "Is there such a thing as an affective objective?" Some of his major points include:

a. By the time a bona fide objective is written, it will be devoid of abstractions.

b. Objectives describe performance.

c. Performance can only be cognitive or psychomotor. Affective words cannot describe action.

One conclusion Mager draws is that since there are no affective words adequate for describing performance, and as performance is the sine qua non of an objective, by definition there are no affective objectives per se. Yet this is not the end of it. He suggests that the question of whether or not there are affective objectives may be the wrong question. The essential question appears to be, "Can behaviors indicative of attitudes or feelings be changed in desired directions by objectives devoid of affective words?"

Mager (1977) contends, and the author agrees, that an objective need not contain affective words such as "love," "respect," and "genuine sincerity" to deal with affective constructs. Well-written objectives emanating from affective goals will be bare of affective words, yet will serve the purpose of an affective goal if the goal developers are satisfied that the sum of the performances described by the objectives fulfills that which was intended by the goal. In the example below, in which the competency stage is omitted, goal developers may well be satisfied by the objectives representing their goal.

Goal

To understand how to speak to residents in a respectful manner that encourages communication.

Objectives

Over a two week period, in four out of five instances of ten minutes or longer, in which the RA trainee or resident(s) is trying to communicate with the other, the trainee will:

a. Look at the face(s) of the resident(s) when the resident speaks to him, at least 50% of the time.

b. Make verbal responses or gestures that attempt to address the questions or concerns directed to him by the resident(s), 100% of the time.

c. Paraphrase the major ideas presented by the resident(s) and ask clarifying questions when feedback indicates that the paraphrasing was incorrect or incomplete, 80% of the time.

d. Ask the resident(s) questions that reveals more detail about the nature and dynamics of his feelings when he expresses that he is "feeling" bad, 80% of the time.

e. Wait until the resident has completed speaking or gesturing before initiating verbal or gestural statements of more than 5 seconds, 100% of the time.

f. Make positive comments without interrupting the flow of conversation when a resident says or does something his IHP or IPP indicates he should do, at least 30% of the time.

g. Speak in a manner that evokes verbal or motoric responses from residents which are consistent with the flow of conversation (e.g., subsequent comments are an elaboration or modification of previous comments), 80% of the time.

h. Speaks without shouting at the resident(s).

i. Speaks without making remarks that two impartial observers are likely to interpret as derogatory, sarcastic, or disparaging.

The only exceptions to objectives "a" through "h" are when:

a. The situation is dangerous (objectives "a" through "f" and "h" are suspended if justified).

b. The resident is verbally and gesturally rambling without making sense to the trainee or others involved (objectives "a" through "e" are suspended if justified).

c. It is contradictory to the specifics of the resident's IHP or IPP (objectives "a" through "h" are suspended if justified).

d. It is considered disruptive to ongoing activities by the trainee and one other person, if available (objectives "a" through "f" are suspended if justified).

It may well be that another group of program developers with the same affective goal will not be equally satisfied by these objectives. They may find the objectives incomplete, misdirected, and with the four exceptions listed, too complex. Thus program developers are urged to reduce abstraction, ambiguity, and the like by specifying exactly what they expect RA trainees to do to satisfy their program goals by formulating program-specific objectives from program goals and competencies. Such formulations would make clear the different meanings which various individuals ascribe to the same goals on which they appear to agree.

The commentary and example presented in this section illustrates movement toward more observable and measurable descriptions of intent. The essential meaning of the goal was translated into a series of behavioral statements devoid of affective words but clearly indicative of achievement or the lack of it, vis-a-vis the author's personal conceptualizations of the goal. Seeking clarity of meaning for an affective goal did not change or lessen its meaning, but opened it up to congruent interpretation and provided parameters for observation and measurement. As Mager (1977) has said so well:

> The procedure for clarifying goals has nothing whatever to do with humanistic or antihumanistic sentiments, or even how 'affective' the goal itself may be.

> To describe the world is not to change it. To say what one means by a goal is neither to reduce the importance of the goal nor its profundity (p. 71).

7. A number of the competencies appear to be repeated in other sections. This is unnecessary duplication.

An examination of the competencies contained in this document should reflect what appears to be some redundancy. There are several reasons for this. First, the subject areas under which the competencies are organized are not mutually exclusive, and thus the competencies are not mutually exclusive. The apparent repetition of competencies across areas is simply a reflection of the interrelationships among the content areas. Second, it is felt that many users might want to consider the various subject areas separately and would prefer that the competency listings comprising the subject areas be complete. This permits using or extracting particular competency listings without fear that they contain significant conceptual gaps. Third, it is believed that what appears to be the same or a highly similar competency, manifested in a different setting or emanating from a dissimilar context, makes somewhat different demands upon the trainee and hence in actuality is not the same competency. Moreover, behavioral objectives emanating from apparently similar competencies may be dissimilar given the diverse subject areas from which they emerge. Finally, requiring the same or a related response in a variety of situations allows for a more reliable estimate of the ability the competency is designed to tap. When dealing with behavior several related assessments are likely to be more reliable and thus less dependent on chance than a single assessment. Assessing the same or a related competency at different times during the operation of a program, or under different conditions, may well prove of significant diagnostic value.

CURRICULA FLEXIBILITY FOR INDIVIDUAL STUDENTS

A fundamental promise of fully developed competency-based training programs is that individual or customized learning experiences will be designed which are responsive to individual instructional needs and devoid of redundancy in areas where mastery is evident. Given the traditional course structure of higher education, where course sequences are firmly prescribed on a priority basis, semester hours tightly bound to "fifteen week" semester time frames and courses limited to meeting at set times each week, it does not appear that the competency approach can fully achieve its promise of individualization unless major structural modifications are made in the way academic credits are earned. The following sequence is presented to stimulate thought on this problem of flexibility and individualization. It is presented to suggest the kind of flexibility that might best promote professional mastery in fields where performance with clientele is most important. As with the majority of ideas in this document, it must be tailored to the unique demands and constraints of local realities. Thus, the following points are presented for consideration:

1. Each trainee entering the professional sequence is given a validated battery of multiple choice questions designed to assess his detailed knowledge of the field. The questions assess the trainee's ability to recall, summarize, predict from, evaluate

and apply knowledge (Miller, Williams, & Haladyna, 1978) believed essential for effective functioning as an RA.

2. Trainees are assigned to cognitively oriented semester length courses, mini-courses, learning modules, and specifically designed educational experiences of varying lengths based on their entry level test performance. Each experience derives from a set of competencies for which corresponding objectives have been developed.

3. Trainees who demonstrate mastery of the cognitively oriented instructional objectives alluded to in point "2" and who meet the program's publicly stated behavioral criteria for beginning practica are gradually, but progressively involved in practicum experiences as they individually demonstrate readiness. In other words, practicum involvement would commence when the individual student has met criteria. When others begin practicum would not affect a trainee's starting date.

4. A practicum evaluation procedure, similar to the Resident Advisor Training Evaluation System (Meddock & Margolis, 1979) found in Appendix C, and corresponding to those competencies program developers and instructors deem important for trainees to demonstrate in practicum, is used to evaluate each trainee's progress and to design further practicum experiences. Before such practicum evaluation forms are used with individual trainees, university based instructors and field supervisors representing the practicum site should meet with the individual trainee to review the competencies, their corresponding instructional objectives, and the specific activities in which the trainee will be engaged. At this time the trainee should have the opportunity to:

    a. negotiate for meaning and clear-up and confusion

    b. provide personal insight into his personal development

    c. participate in developing instructional objectives and selecting activities geared to his unique needs

    d. evaluate the requirements of the proposed practicum experience relative to the personal assessment he has made of his abilities

The preceding sequence of events requires flexible time periods, both within days and within calendar periods. For example, both Jon and Marian may have demonstrated competence on most of the program's more cognitively oriented behavioral objectives. Jon demonstrated competence in the third month of the program and Marian in the fifth month. Jon is in practicum for 20 hours a week and Marian for 12 hours. Both are in similar ALA settings. Jon has been allowed to take a progressively more responsible role with residents because he has met criteria for assuming such supervised responsibility and is also beginning to work with more difficult clientele than Marian. Jon attends practicum in the late afternoon and early evening. Marian needs to attend practicum in both the early morning and evening to gain the kind of experiences believed important to her. Edward, on the other hand, has not matched the cognitive achievements of Jon or Marian. He is in practicum five hours per week, in a less directly manner. His primary purpose is not to work with residents, but to observe how residents and staff interact during naturally active periods and to chart the behavior of two residents. Edward spends the bulk of his time in formal classes and also working independently on the same behavior management modules as Marian. Jon has never had the same schedule as Marian or Edward as he "proficiencied out" of two entry level courses on the initial assessment examination. Marian and Edward began three courses together, but halfway through the term Marian demonstrated mastery of the instructional objectives around which two courses were designed and was therefore not required to continue attending. She and her advisor agreed that her time would be better spent if she began practicum at this juncture. In sum, it should be noted that all three trainees began the program at the same time, but due to their individual differences in entry level accomplishments and variant rates of growth and development, they have very different programs at this point in time. Jon will likely be ready for graduation much earlier than the other two. Yet this does not make Edward into a "failure" as he is encouraged to progress at his own rate. If he cannot demonstrate continuous growth vis-a-vis the program's competencies, he and his advisor will be able to use the information from the instructional objectives to make an informed decision on his continuing in the program or revising his individual curriculum.

A flexible structure such as the one described in this section also requires the termination of tying grades to traditional courses which must be completed by semester's end. Fixing evaluations or grades to clusters of competencies and their corresponding instructional objectives rather than to traditional courses provides potential employers and others with a more detailed and realistic understanding of what the RA trainee has accomplished. Moreover, it adds positively to the instructional process by:

1. Not creating time and grade pressures which force trainees to do that which they're not ready to do

2. Allowing instructors and trainees the liberty of focusing on assessed deficits in a context relatively free of defensiveness

3. Simultaneously involving instructors in the evaluation and design of individual trainee's programs

4. Not penalizing slow starters or boring rapid learners with unnecessary redundancy

Essential to the scenario of maximum instructional flexibility is

1. A validated battery of multiple choice questions designed to assess the trainee's knowledge base

2. Instructional objectives with realistic, field-tested criteria

3. A host of programmed instructional modules geared to remedying deficiencies or providing enriching experiences in priority areas

4. A wide variety of practicum sites which are readily accessible to trainees

5. A large cadre of highly trained RAs who are dedicated to professionalizing the field through the improved training of new RAs

6. Program faculty who are primarily evaluated for their instructional and counseling contributions

7. An adequate number of supervisory and instructional personnel involved in practicum to the degree needed, as needed

8. Time for reflection and program readjustment

9. An administration committed to providing the program with the flexibility needed by clinically oriented programs and which recognizes program achievements rather than just problems

To believe that this will come easily with a year or two of intense effort is to fantasize. It will take far longer. To skillfully work for its achievement in a systematic fashion is to take the first steps necessary to making such conditions a reality.

## THE RELATIONSHIP BETWEEN COMPETENCIES AND THE DEMANDS OF THE JOB

From an examination of the job descriptions gathered from state and local agencies, discussions with RAs and the Advisory Board for the project, it became abundantly clear that there was no single job description that accurately described the daily tasks of the RA. The nature of the RA's job and the demands placed upon the RA appeared to be a function of numerous factors which included:

1. The staffing pattern of the ALA

2. The type or mode of deviations characterizing residents

3. The intensity and extensity of the disabilities exhibited by residents

4. The support systems available and the responsiveness of these systems

5. Local administrative policy

6. The skills of fellow RAs

7. ALA location

8. Informal, unwritten, and often unstated norms of functioning.

Since a narrow delineation of RA functioning and the knowledge, skills and attitudinal demands placed upon RAs would be off the mark in so many cases, the competencies contained in this chapter reflect a broad range of skills and attributes from which program designers may want to select and prioritize. As previously discussed, such a process should be sensitive to and reflective of local practices and demands. It should also take into account official state job descriptions such as those discussed in the preceding chapter. The reader should be aware, however, of the frequent disparity between such descriptions and the actual demands of employment. Thus, the reader is urged to go beyond written job descriptions. He is urged to interview local RAs, provider agencies, and the like, and involve them in selecting the competencies, formulating the instructional objectives, and evaluating the program's graduates.

## SECURING SUPPORT FOR IMPLEMENTING NEW PROGRAMS

Volumes have been written on implementing new ideas and this brief section will not attempt to compete with this vast array of well articulated knowledge. Rather, this section will focus on listing some fundamental principles to which program developers would be wise to adhere. First, "brilliantly" conceived strategies and carefully detailed plans are not sufficient alone. The confidence, composure, tenacity, and listening skills of those involved in developing and implementing new programs and their ability not to personalize events may be just as essential for successful program implementation.

Houston (1974) believes that to bring about viable curriculum changes of major proportions, one must "(1) change the perceptions of the people who are involved in . . . education; and (2) reconceptualize the organizational and governance structure; as (3) the program is developed." In addition, it should be recognized that "a change in any of these three targets of change will bring about changes in the other two and in the totality" (p. 28). He suggests strict adherence to the following principles when attempting to develop new points of view in people and organizations:

### People

1. Provide opportunities for the exploration of competency-based education and other basic ideas by those involved in the process (e.g., hold a retreat and honestly exchange views).
2. Provide opportunities for people to be involved to the extent they wish.
3. Provide continual opportunity for feedback and reorientation (e.g., orient new people and assist those who have been oriented to increase their understanding).
4. Institute a reward system that is consistent with the program objectives and program outcomes.

### Organizations

1. Clarify the roles and responsibilities of those institutions and agencies involved in the program.

2. Provide direct involvement as near the power sources as possible (e.g., department chairpersons, deans, vice presidents, funding agencies, and the like).

3. Set goals for management and obtain feedback on progress toward those management goals.

4. Plan for the process (e.g., develop a time line of events and determine responsibilities).

5. Make relatively short assignments with specific terminal outcomes vis-a-vis the tasks to be accomplished.

6. Plan for regular meetings of the staff and governance bodies to maintain communication, obtain feedback and refine plans.

7. Provide time to clarify issues and work through differences, particularly as inter-institutional arrangements are developed.

8. Make decisions considering the program thrust and not institutional biases.

Resistance to change, whether the change is in the form of a revolutionary social idea or a new curriculum, is natural and should not summarily be interpreted as evidence of a diabolical plot to maintain the status quo at the expense of "true" and "justified" progress. Recognizing the frequency of resistance, and the devastating effect it can have on program development, UCPA's Task Force on Staff Development focused considerable effort on detailing the dynamics of change and the implementation of ideas. The passages and diagram which follow are from the UPCA's Staff Development Handbook: A Resource for the Transdisciplinary Process (1976). The material establishes a conceptual framework for understanding the dynamics of change and resistance to change which program developers will face in one form or another. Careful study of the selection and discussion of its message with respect to local realities should assist program developers in gaining acceptance for their ideas. While some of the concepts in the UCPA material have been alluded to in previous sections of this chapter, several essential ideas have not been examined. Of these latter ideas, especially important are those dealing with the way innovation is perceived by its potential adopters and the identification of crisis points which call for supportive interventions. Failure to translate these ideas into action when promoting and implementing programs are bound to have severe adverse affects on all involved.

## Resistance to Change*

Any change in a system will cause other parts of that system to change as well. Almost certainly, then, as the successful use of the

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*Quoted with permission

[XYZ Approach] . . . evolves, other changes will occur within the agency, its administration, and its funding mechanisms, its clientele, and ultimately, the community at large.

Model I (Figure 3) provides an overview of the social system of change. Step I, the Innovator (or Creator of Change), indicates the creative phase when a new idea is conceived or a new practice is generated.

Step II is the Initiator. Here the base of involvement is broadened by including leaders who are capable of planning and taking early action to endorse and support the Change.

Step III is the Legitimizers. This concerns the "sanctification" by leadership of the Change, the "legitimizer function." Though possibly critical of the Change in the beginning, most members of this group, once won over to the idea, will remain constant in their support of it.

Step IV identifies the Interpreters. They conceptualize those forces necessitating the Change. They explore for others the salient features of the Change, and they project its expected outcome.

Step V, the Diffusion Set, brings together a still larger aggregation who utilize the efforts of groups I-IV. This group usually has significant credibility, stature, and widespread influence within the social system; they have access to other groups and therefore are capable of disseminating information as a diffusing set. They are effective in communication with other groups as well as successfully operating on an interpersonal plane.

Step VI is the Early Adopters. They enjoy validity from others as opinion leaders. Persons in this group are characterized by their reliance on their own considered judgment. By accepting the Change early on, this group carries great weight within the social system.

There is also an appendage group to the Early Adopters. These are the "More Cautious Early Adopters." They watch for a while; they see the success Early Adopters receive from accepting Change; then they sit back and give the Change Idea still further consideration, and, finally, they decide to adopt it. These Early-Late Adopters still accept the Change early on, but they are not the first to accept it.

The final step, Step VII, is taken by the Late Adopters. This is the skeptical group. They are pleased to have some one else "do it first." They cling to their "wait and see" attitude for such a length of time that Innovation is permitted to become (almost) the established practice before they join with others in practicing it.

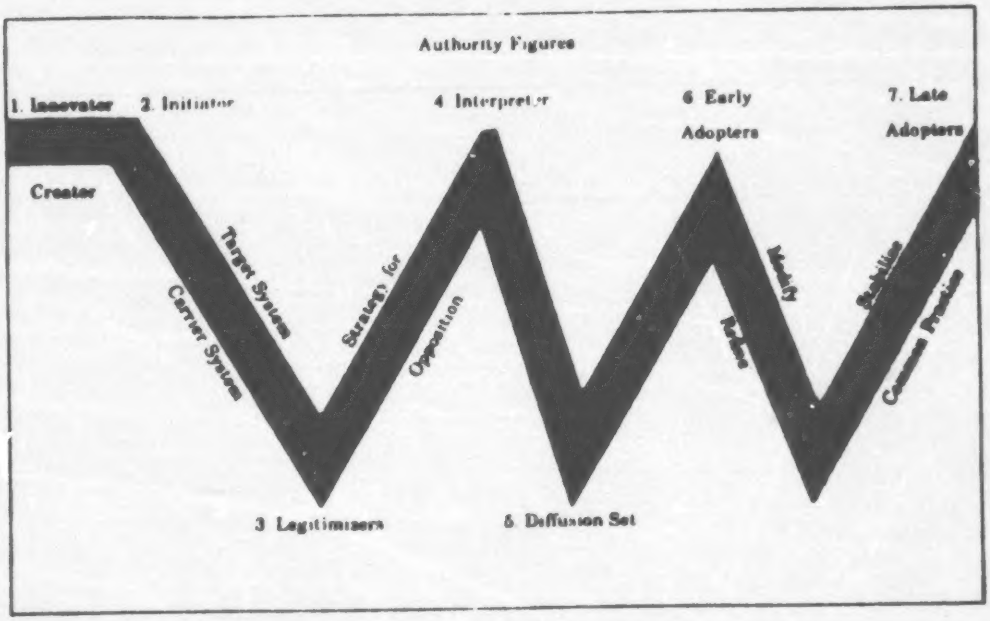
There is, however, one final group which must also be recognized. This eighth group is the "Never Adopters." Never Adopters resist change. They cling to old methods as Linus does to his security blanket. Some social scientists apply the more kindly term "laggards" to this group, but these social scientists are hoping that the "laggards" will convert.

It is a dilution of effort to spend precious time and resources in an attempt to change the Never Adopters. Their main source of satisfaction is derived from resistance. If they are truly "laggards," peer pressure may, in time, produce the conversion. If, however, they are truly Never Adopters, time can be relied upon only to phase out The Old Guard.

Paradoxically, the entrenched attitude of the Never Adopters serves a useful purpose. Their obstinacy slows down a Change that might otherwise be accomplished without sufficient deliberation and thought.

Figure 3

Overview of Social Change



## Accepting the Innovation

Innovation, the beginning of Change, has been defined by Martin Trow as ". . . a break with routine and habit; it disrupts unreflective ways of thinking, feeling, behaving. It requires a heightened measure of attention and interest in the matters at hand; it forces the participants, and especially the innovators, to think in fresh ways about familiar subjects, to reconsider old assumptions."

It has been suggested by some authorities that a project can be considered innovative if it is directed toward a new clientele, if a different methodology is employed, or if the context in which it operates has new dimensions. When these elements are present, the proponents of the innovation can expect a dynamism to permeate their effort. The innovation may even become controversial; but at any rate, it is certain to be highly visible, and there will be heightened interest in the results of the project by any number concerned.

How is innovation accepted and supported? These grow out of the way innovation is perceived by its potential adopters. Five major characteristics of innovation, which contribute to the perception of the Change by its potential adopters, are cited here:

1. Relative Advantage - The new idea will be weighed against what has preceded it. It must be seen to be better than the idea or operation that preceded it.

2. Compatibility - The new idea will be evaluated to see if it is an overlay or extension of the old one. Does this new idea "fit" into the present philosophy and practice of the social system and agency?

3. Complexity - The new idea will be examined to the degree of difficulty one experiences in understanding and instituting the Change.

4. Trialability and Divisibility - The innovation will be checked to determine its potential for general or partial application.

5. Communicability - The innovation will be assessed for the ease with which new ideas can be interpreted and utilized; the degree to which anticipated results are observable.

It can be expected, then, that innovation has the potential of breeding heady excitement, especially for its Creators and Early Adopters. Innovation has the potential to shake seasoned staff members out of their comfortable ruts. It can reduce the boredom of everyone and break up unthinking habits and routines by giving rise to fuller use of present knowledge and stimulating the acquisition of new knowledge.

Newness captures the imagination. New programs tend to succeed because of the experimental surroundings in which they are practiced, refined, and polished. Everett M. Rogers in his work on the diffusion of innovation has suggested five stages that illuminate the nature of the diffusion process which leads to the adoption of a new idea or practice by an individual. These are the five stages:

1. Awareness - The person has heard or read of the idea or practice, but the fund of information is limited.

2. Interest - The person seeks further information from what is considered to be authoritative sources.

3. Evaluation - The person explores the applicability of the idea or practice to his or her own situation. The individual may also seek the evaluation of others whom he or she respects.

4. Trial - The person decides to try it. The trial may involve action testing in part or in whole. Attempts to minimize risks may involve initiating the new idea on a small scale and paying careful attention to such outcomes.

5. Adoption - If the idea or practice proves acceptable on a small scale, the person fully implements the tested idea.

Worth attention, too, is Kurt Lewin's "theory of disequilibrium" as it applies to accepting change. Lewin's theory suggests that disequilibrium is a necessary forerunner to the acceptance of change. The first stage of disequilibrium produces dissatisfaction with the present. This gives rise to the second stage, which is producing a behavior that resolves the disequilibrium. The final stage recognizes that by progressing through stages one and two, equilibrium (as far as the change is concerned) is restored and stabilized.

## Supportive Interventions

Sister Mary Brigid Condon identifies four crisis points in the change process which can be anticipated and which call for supportive interventions:

1. When the proposed changes register with the individual.

2. When the individual understands the changes.

3. When the changes become functional with the individual.

4. When the change is internalized by the individual.

Sister Mary Condon has also outlined the types of interventions which are called for:

1. Strong and effective leadership when the proposed changes register.

2. Intensive educational programs when the changes are understood.

3. Time--lots of it--so that the individual may make the change functional.

4. Supportive services when the changes are internalized by the individual, so that he or she may further develop and grow with the function of the changes.

Most post-secondary institutions require that new programs and curriculum changes proceed through a rigorous, layered bureaucratic and academic review process. Conforming to the details of the process does not guarantee that the program will receive the support it needs but does, together with the networking for support alluded to throughout this chapter, afford a margin of safety. Regardless of the support engendered by formal and informal networking activities, failure to identify the formal and informal elements of the approval process well in advance and failure to adhere to them will most likely prove disadvantageous, time consuming, and painful. It may also result in disapproval, irrespective of the program's merits. A sample set of formal procedures which need to be followed at Edinboro State College is found in Appendix D. Some schools require both a greater number of steps and more detail, and no doubt, some are not as demanding. The potential program developer is urged to obtain his school's formal documentation outlining the steps he needs to follow and discuss the meaning of each step with those parties responsible for making decisions at each stage and those who have had experience in successfully negotiating the steps within the school.

## ORGANIZATION OF THE COMPETENCIES

Following is a listing of the subject areas under which the competencies have been organized:

Advocacy and Legal Rights
Behavior Change
Case Management
Definitions and Causes
Group Process
Human Development
Individual Program Design, Implementation and Evaluation
Instructional Analysis
Medically Complex and Multiply Handicapped
Normalization
Problem Solving
Program Maintenance
Severely and Profoundly Impaired Track
Vocational Appraisal

This particular organizational scheme was chosen because it is logical, easily comprehended, and consistent with the structure of most post-secondary introductory curricula in the helping professions. It was reasoned that because it paralleled already existing curricula, matching the competencies to courses would be less difficult than if the organization differed markedly from existing course structures. On the other hand, a strong argument can be made for organizing competencies by RA function rather than by subject areas. As the author sees equal merit in both approaches, an abbreviated listing of competencies by function is found in Appendix E. The nine areas of function* are:

1. Creates and maintains normalizing living arrangements.
2. Designs, manages, conducts, and evaluates resident training programs.
3. Provides physical care.
4. Relates with others in one-to-one situations.
5. Relates to others in group situations.
6. Knows how to use resources and legislation.
7. Identifies physical, psychological and sociological aspects of developmental disabilities.
8. Maintains own effectiveness.
9. Advocates for those needing advocacy.

It should be noted that within subject areas the competencies are not organized in a hierarchial or purely sequential fashion. Wherever the subject matter allowed, the competencies were organized sequentially from simple to complex, from elementary to advanced. However, many subject areas did not lend themselves to an organization in which each preceding competency was a prerequisite for mastering the next competency. This affords the reader the opportunity for rearranging the sequence of competencies within subject areas. Before so doing, however, he should consider that a competency is a data or summary point. It often represents a cluster of subskills or abilities that must immediately fuse together at an end point in time. In other words, although a subject may not appear to be covered in the detail the reader wishes, or on the surface the competency may not require the smooth blending of a variety of skills and concepts, in actuality, this is exactly what may be required for the demonstration of mastery. Thus the reader is urged to identify the implicit sub-elements of each competency before reorganizing the order or eliminating competencies. The best way of doing this is to develop instructional objectives for the competencies in question and to list what one needs to know or do to evidence mastery.

The over five hundred competency statements which follow have been contributed and/or revised by resident advisors in the field, project Advisory Board members, expert consultants and project staff. While currently this listing is probably the most comprehensive collection of competencies specifically designed for ALA services, it should not be viewed as complete nor free from benefit for thoughtful and constructive revision.

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With that perspective in mind, the competency clusters are presented below, each cluster being preceded by a goal statement broadly defining it's purpose for inclusion.

### 1. Advocacy and Legal Rights (ADV)

#### a. Goal

To understand and effectively utilize those concepts which are essential for successfully advocating for ALA residents.

#### b. Competencies

The RA Trainee should be able to:

ADV 1 Describe "Implementive" and "Expressive" functions and needs as given meaning by Parsons and Bales (1950) and Wolfensberger (1973).

ADV 2 Cite three examples each of one's own (resident advisor's) implementive and expressive needs and identify similarities and differences among these examples.

ADV 3 Cite three examples each of occasions when RAs own needs, implementive and/or expressive, are in conflict (e.g., need to earn a living at work vs. need to interact affectionately with family at home).

ADV 4 Elaborate upon the term "conflict of interest" and cite ten examples of how one's own interests have come into conflict with the interests of others. Further describe in each case how the conflict was resolved.

ADV 5 Relate five episodes from one's own experiences in which a service was provided by a large organization such as a hospital, college, department of government, department store, etc. and identify specific instances in which needs and interests were in conflict with (a) the large organization, (b) individuals working within the large organization.

ADV 6 Think of ten people, family, friends, oneself or acquaintances, who were or are in need of the prolonged services of a professional agency and describe the attitudes and orientations of the agency person (professional) who provides the service and the person (patient, client) who receives the service.

ADV 7 Identify ten kinds of people who are substantially in need and who receive extensive services from caregivers and other professionals (e.g., children, the aged, mentally retarded, persons accused of crimes, etc.).

ADV 8 Catalog sixteen services provided people in need and identify those which are provided to "normal" people (e.g., transportation services, medical diagnosis, education, etc.).

ADV 9 Anticipate and describe ways in which the interests of those who provide these sixteen services may come into conflict with the interests of the person who receives the service (e.g., mainstreaming removes disabled from special classes).

ADV 10 Define advocacy and identify key definitional concepts as presented in standard dictionaries.

ADV 11 Further identify three additional concepts suggested by Wolfensberger as necessary descriptors of advocacy; i.e., vigor and vehemence, personal costs to advocate, and absence of conflict of interests.

ADV 12 Name ten kinds of advocates or people who speak or write in support of someone or something in our society.

ADV 13 Cite two examples from personal experience when an advocate was needed or could have been helpful and compare similarities and differences between these circumstances.

ADV 14 Understand and describe the role of an implementive advocate to be one of speaking or writing to someone on behalf of a person to help him or her obtain needed services or material goods.

ADV 15 Understand and describe the role of an expressive advocate to be one of speaking or writing to someone to help on behalf of a disabled person obtain fulfillment, affection, self esteem and his/her human needs.

ADV 16 Understand and so describe the advocacy role of the resident advisor to be one of speaking or writing to someone on behalf of the resident in order to help meet both the resident's implementive and expressive needs (e.g., the RA needs to fulfill both types of advocacy functions).

ADV 17 Illustrate five criteria for judging what is in a resident's best interest.

ADV 18 Evaluate the relative importance, in specific case studies, of criteria such as legal rights of citizenship, physical health, normalization, financial support for resident and his or her program, and time allotted to program as determinants of the resident's best interests.

ADV 19 Design integrated, interdisciplinary methods for resolving conflict between criteria used to determine a resident's best interests.

ADV 20 Describe procedures used in individualized planning common to educational, habilitative, vocational and other programs.

ADV 21 Prepare information, forms, scales, checklists and other narrative materials for use in multidisciplinary planning or formal due process hearings.

ADV 22 Recognize and elaborate upon the importance of accurate and timely documentation or "case notes" regarding the resident and RAs interactions with service providers.

ADV 23 Identify agencies and individuals who provide services and name those which are required by law to do so.

ADV 24 Describe the general entitlements and standards for services provided to disabled people in education, vocational rehabilitation, supplemental (social) security income (SSI), medical program and under Pennsylvania's MH/MR Act of 1966.

ADV 25 List in sequence steps to be taken when services for which the resident is entitled appear to be denied or provided in substandard fashion.

ADV 26 Present factual information to multidisciplinary team meetings or formal due process hearings.

ADV 27 Itemize in detail, citing current source documents, all legally entitled services and applicable standards in the areas of education, vocational training, medicaid, social security benefits and MH/MR services under PA Act of 1966.

ADV 28 Identify and diagram the organizational structure of systems mandated to provide services in the areas of education, vocational training, medicaid, social security and MH/MR services.

ADV 29 Name the official and his or her immediate supervisor in each system who is responsible for providing services to residents.

ADV 30 Describe the procedures required to initiate claims for services in each system which provides legally mandated services to ALA residents.

ADV 31 Trace the appellate steps and/or procedures available to advocates as are applicable to each system which provides legally mandated services to ALA residents (include the ALA system).

ADV 32 Demonstrate understanding of the "equal protection" principle of the 14th Amendment to the Constitution.

ADV 33 Catalog resources available which may aid in pressing claims for services on behalf of ALA residents (to include resources such as Pennsylvania's DD Advocacy Network, various legal aid centers, professionals, parents and parent associations, volunteers, etc. and in case studies devise strategies employing these resources to enforce claims for the services.

ADV 34 Catalog resources available to help influence generic service providers to serve ALA residents and in case studies develop strategies to employ such resources to increase resident access to generic services.

ADV 35 Identify the difference between guardianship of the person (total guardianship), guardianship of property and limited guardianship.

ADV 36 Define in operational terms the meaning of the principle of "informed consent," "right to treatment" and "right to refuse treatment."

ADV 37 Enumerate and describe the services resident advisors provide to residents of the ALA.

ADV 38 Name three advocates for residents who may criticize the RA of the ALA program, and identify factors which will influence the RAs response(s) to such criticisms.

ADV 39 Select of several alternatives the most productive responses to advocate criticism of services provided in ALA program.

ADV 40 List and discuss steps to be taken when an advocate (parent, friend, representative of another agency, etc.) criticizes the services provided to residents in your ALA program.

ADV 41 Trace the appellate recourse steps available to external advocates who criticize the services provided to residents of your ALA program.

ADV 42 Outline strategies to resolve conflict between advocates for ALA residents (parents, friends, representatives of other agencies, etc.) and ALA resident advisor staff regarding the provision of ALA services.

ADV 43 Outline five situations in which external advocates could positively affect the provision of services within an ALA and discuss measures RAs could use to solicit the aid of such advocates.

ADV 44 Demonstrate full appreciation of the need for, and implications of, the term "redundancy of safeguards" as it applies to services to the disabled.

ADV 45 Apply the concept "redundancy of safeguards" and describe six mechanisms which might be used to redundantly safeguard the rights and dignity of persons living as residents of an ALA.

ADV 46 Identify the three domains in which our society establishes standards which affect ALA residents and other disabled people, Judicial, Legislative, Executive, and demonstrate understanding of the principle methods used to alter standards in each of these domains.

ADV 47 Suggest at least six creative ways that ALA resident advisors and residents can positively affect the public's, their neighbors, acceptance of and attitudes toward disabled people . . . and so affect society's standards of treatment.

ADV 48 Discuss the differences among "class" or "systems" and "case" level advocacy, and advocates who work in these areas (e.g., lawyers, ombudsmen, citizen advocates, etc.).

ADV 49 Catalog generic service agencies or systems which are not or may not be specifically mandated to serve disabled people (e.g., private clubs, transportation systems, recreational facilities, restaurants, dental and medical practitioners, and others who serve the general public).

ADV 50 Prepare a brief, summarizing at least six hypothesized potential situations which you (the RA) would find intolerable with respect to your own values and which would require you to resign from the ALA system.

ADV 51 Name five professional colleagues in the U.S., whose respect you value sufficiently to share your brief and with whom you may vow to maintain a close and mutually supportive relationship with over the years.

## References for Advocacy and Legal Rights Competencies

Bancom, L., and Bensberg, G. (Eds.). *Advocacy systems for persons with developmental disabilities: Context, components, and resources*. Proceedings of the conferences *Developmental disabilities advocacy and protective services* (Kansas City, Missouri, September 26-29, 1976; San Francisco, California, October 5-8, 1976; Washington, D.C., October 12-15, 1976). Lubbock, Texas: Research and Training Center in Mental Retardation, Texas Tech University, 1977.

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Shearer, A. The caring staff. In R. Kugel and A. Shearer (Eds.), Changing patterns in residential services for the mentally retarded (revised edition). Washington, D.C.: President's Committee on Mental Retardation, 1976.

Turnbull, H. III (Ed.). Consent handbook of the task force of the AAMD legislature and social issues committee, 1975-76. Washington, D.C.: American Association on Mental Deficiency, 1977.

Wolfensberger, W. A balanced multi-component advocacy/protection schema (Law and mental retardation: A monograph series). Toronto, Canada: Canadian Association for the Mentally Retarded, 1977.

Wolfensberger, W., and Zanha, H. (Eds.). Citizen advocacy and protective services for the impaired and handicapped. Toronto, Canada: National Institute on Mental Retardation, 1973.

## 2. Behavior Change (BC)

### a. Goal

To understand and be able to apply the principles of behavior change in ways that will positively assist ALA residents in achieving their potential.

### b. Competencies

The RA Trainee should be able to:

| | |
|---|---|
| BC 1 | Define the basic terms used by the instructor and course materials in the discussion of behavior management. |
| BC 2 | Explain the basic principles of behavior management alluded to by the instructor and the course materials. |
| BC 3 | Define behavior. |
| BC 4 | Operationally define two specific behaviors observed in the presence of the instructor. |
| BC 5 | Explain the statement "Both reinforcement and punishment can only be defined by their effects." |
| BC 6 | Specify how respondent and operant conditioning differ. |
| BC 7 | Distinguish between two prominent theories for influencing behavior (e.g., behavior management and Roger's Client Centered Therapy) with respect to the underlying assumptions of each theory and |

the basic steps and principles involved in producing changes in the desired directions.

BC 8 Specify and define the prominent variables (e.g., discriminative stimuli; reinforcement principles) used by a particular theorist or school of thought to explain how individual and/or group behavior is influenced and provide an illustration of how these variables or principles interact to affect behavior.

BC 9 Specify those factors which should be considered before deciding that a particular behavior is sufficiently inappropriate and needs to be modified (e.g., the behavior is harmful to others).

BC 10 Write a comprehensive set of instructional objectives for a resident based on given data. The objectives should conform to Mager's (1975) formulations for performance, conditions, and criteria.

BC 11 List and describe the type of data that should be collected, given a set of instructional objectives.

BC 12 Write a plan for collecting data to satisfy a given set of instructional objectives.

BC 13 Evaluate whether or not an instructional objective has been achieved, using given data as the basis for the evaluation.

BC 14 Collect relevant data in accordance with a plan to monitor a resident's progress vis-a-vis an instructional objective and present a rationale for maintaining or modifying the objective and/or the intervention strategy, based on the data obtained.

BC 15 Explain the meaning and implications of the statement, "Behavioral problems are usually relative. They lie in the eyes of the beholder."

BC 16 Summarize an ethical argument concerned with each of the following:

(1) deciding that a behavior needs to be controlled or modified
(2) choosing procedures for controlling and modifying behavior
(3) releasing information about residents

BC 17 Provide examples of the following reinforcement schedules: continuous, fixed ratio, variable ratio, fixed interval, and variable interval.

BC 18 Contrast the behavior patterns characteristically associated with each of the reinforcement schedules listed and describe the effects of each of these schedules under extinction conditions: continuous, fixed ratio, variable ratio, fixed interval, and variable interval.

BC 19 List those questions that should be answered when selecting a reinforcement schedule and deciding on the nature and amount of reinforcement.

BC 20 Explain how in a particular instance the elements of a theory of behavioral change provided the framework for generating solutions to a behavioral problem observed in an ALA.

BC 21 Analyze the environment of an ALA to a degree sufficient to isolate those variables responsible for:

(1) a resident maintaining target behaviors selected for reduced emission or elimination
(2) inhibited development of a desired behavior by a resident.

BC 22 Describe a situation in which each of Blackham and Silberman's (1975) four basic behavior change strategems would be most appropriate:

(1) extinction and positive reinforcement
(2) modeling and positive reinforcement
(3) role shift and positive reinforcement
(4) behavior contract, positive reinforcement and withdrawal of reinforcement

BC 23 Describe, in a step by step fashion, how each of Blackham and Silberman's (1975) four basic behavior change strategems would be applied, given case data:

(1) extinction and positive reinforcement
(2) modeling and positive reinforcement
(3) role shift and positive reinforcement
(4) behavior contract, positive reinforcement and withdrawal of reinforcement

BC 24 Arrange the environment so as to:

(1) lessen the occurrence of a resident's behavior selected for reduced emission or extinction

(2) assist the resident in increasing the occurrence of a desired behavior with a low operant level
(3) assist the resident in developing a new behavior
(4) assist the resident in maintaining a specified behavior at a given rate

BC 25 Operationally define and generate specific strategies to help residents overcome problems of:

(1) aggression
(2) impulse control
(3) hyperactivity
(4) distractibility
(5) withdrawal
(6) inadequate social perception
(7) poor interpersonal relationships
(8) confidence and self-worth
(9) poor motivation

BC 26 Delineate and implement a strategy for assisting a resident in generalizing a newly acquired self-control behavior (e. g., putting his hands in his pocket rather than hitting someone when angry) to a variety of physical settings and persons.

BC 27 Describe a strategy that would likely be effective with a given resident in reducing stress and illustrate how the resident should be encouraged so that he will voluntarily use the strategy to reduce stress.

BC 28 Define stimulus control and list the principles that should be adhered to for strengthening the control of a stimulus.

BC 29 Explain why behaviors which are learned in one situation or with one person often fail to generalize to other situations or persons.

BC 30 Develop a monitoring system for a behavioral change agent or targeted individual that will clearly and accurately represent progress made, given behavior to be increased and/ or decreased.

BC 31 Develop a case study of a resident who exhibited severe behavior and/or learning problems before treatment. Clearly delineate:

(1) the nature of the problem(s)
(2) probable causation
(3) the treatment objectives

(4) the treatment provided
(5) the results obtained
(6) recommendations for the future

Provide supporting evidence for the conclusions reached in sections (1), (2), and (6) and elsewhere, when warranted.

BC 32 Discuss with the involved resident(s), his parents, and the professionals participating in the resident's program, those behavior management techniques and strategies which will be applied to the resident so that commensurate with capacity they:

(1) paraphrase the goals and/or objectives of the intervention
(2) describe the major elements of the intervention strategy
(3) describe what they should and will do to enhance the probability of successful intervention

BC 33 Formulate a plan for motivating relevant individuals to cooperate with the behavioral management strategies being considered or employed.

BC 34 Analyze the requirements of a given task and present it in such a manner that residents are able to successfully accomplish the task without exhibiting undue frustration or dissatisfaction.

BC 35 Give feedback that is descriptive, refers to a standard (e.g., "You did exactly what was agreed to. It works perfectly.") and is devoid of personally oriented value-laden terms (e.g., "That's a poor job. It indicates you didn't put much thought into it.").

BC 36 Accept feedback as evidenced by behavior changing as recommended.

## References for Behavior Change Competencies

Blackham, G. J., and Silberman, Adolph. Modification of child and adolescent behavior. Belmont, California: Wadsworth Publishing Company, Inc., 1975.

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Rogers, C. R. "A theory of therapy, personality and interpersonal relationships all developed in the client centered framework." In S. Koch (Ed.), Psychology: A study of a science, Volume 3. New York: McGraw-Hill Book Company, 1959.

Rogers, C. R. The great response style myth. Psychological Bulletin, 1965, 63, 129-156.

### 3. Case Management (CM)

#### a. Goal

To understand how case management teams should operate and to effectively implement the role of a resident advisor on such a team.

#### b. Competencies

The RA Trainee should be able to:

CM 1 Define case management.

CM 2 Describe the essential components of a case management plan.

CM 3 Identify those individuals who should be involved in designing and refining a case management plan for a resident.

CM 4 Describe the legitimate functions of professions usually involved in the diagnosis and case management of residents.

CM 5 Describe the role and responsibilities of a resident advisor as part of a case management team.

CM 6 List the basic questions specified professions should be prepared to answer, vis-a-vis the needs of residents.

CM 7 Describe the basic data gathering procedures used by specified professions usually involved in case diagnosis and management (e.g., how does a psychologist ascertain a resident's level(s) of adaptive behavior?).

CM 8 Define the basic terminology used by professions critical to the development and implementation of a case management plan.

CM 9 Specify the primary concerns of resident advisors with respect to diagnosis, case management, and program planning.

CM 10 Specify which members of a case management team should be responsible for designing, monitoring and implementing each essential component of a case management plan.

CM 11 Specify ways in which the RA can best use the services of a case management team and implement one of these ways.

CM 12 Obtain relevant information from a case management team and paraphrase it to the satisfaction of the team.

CM 13 Contribute information concerning resident needs, progress, and program content to the case management team, to the satisfaction of the team.

CM 14 Describe a resident's level(s) of functioning in behavioral terms and present data to support any tentative conclusions which may have been reached about the resident. Indicate the kinds of data needed to validate the tentative conclusions and how such data should be collected.

CM 15 Identify basic factors which inhibit the free sharing of information and opinions in small group situations (e.g., factors which arouse defensiveness).

CM 16 Specify how language and memory factors often distort intended meaning and polarize problem-solving groups.

CM 17 List primary reasons for resistance to change within small groups and detail the actions a group member can take to reduce resistance. Implement these actions.

CM 18 Identify and describe factors generally acknowledged to be responsible for individual behavior in small groups (e.g., reinforcement history, present needs, stereotyped images, individual fantasies, reference to external groups).

CM 19 Explain a basic model of group communication which describes the basic conditions for successful communication, the elements of successful communication and problem-solving, and the characteristics of an effectively functioning group (e.g., as outlined by Andersen).

CM 20 Analyze the basic difficulties a group is having communicating effectively, and devise and implement ameliorative strategies, given a particular case management group.

CM 21 Specify the actions that one can take to enhance the attractiveness and functioning level of a group charged with developing, monitoring and implementing a case management plan. Implement a specific set of those actions given a particular group.

CM 22 Lead a brainstorming session which adheres to the four basic rules of brainstorming (adverse criticism is taboo, "free-wheeling" is welcomed, quantity of ideas is desired, combination and improvement of ideas is sought).

CM 23 Explain the difference between "consensus" and compromise and indicate situations that are appropriate and inappropriate for both.

CM 24 Lead an interdisciplinary group to a consensus plan for working with an individual resident, given a specific set of data.

### Reference for Case Management Competencies

Andersen, M. "A model of group discussion." In R. S. Cathcart and L. A. Samovar (Eds.), Small group communication: A reader (2nd edition). Dubuque, Iowa: William C. Brown Company, 1974.

### 4. Definitions and Causes (DC)

#### a. Goal

To comprehensively define the various categories of developmental disabilities and to understand those factors which cause, influence, or maintain the disabilities.

#### b. Competencies

The RA Trainee should be able to:

DC 1 Define specified exceptionalities and explain the medical, psychological and sociological causes of theses; in presenting the causative factors, distinguish between professionlly agreed upon fact, well-developed theory and opinion.

DC 2 Present a rationale explaining why exceptionality should be defined in terms of modality, intensity, and extensity (Telford and Sawrey, 1977) and distinguish between two given residents along these lines.

DC 3 Distinguish between the validity of statistical definitions of exceptionality (e.g., IQ scores) and pragmatic, social definitions of exceptionality (e.g., inability to talk), as defined by Telford and Sawrey, (1977).

DC 4 List the primary behavioral and physical characteristics of specified exceptionalities; distinguish between those characteristics which are likely to be constitutionally--or genetically--based and those which are likely to be the result of environmental factors.

DC 5 Explain the basis for and the preventative and remedial implications of Smith and Neisworth's (1975) position that deficiencies do not reside exclusively within the individual and are not exclusively the result of a defective constitution.

DC 6 Explain the etiologic, preventative and programmatic implications for individual program planning of the statement: human development is a continuous process in which the individual's constitutional and genetic endowment and reinforcement history continuously interact with the environment to influence his behavior.

DC 7 Diagram how constitutional and genetic factors have interacted with experience and opportunity to influence the behavior of a given resident. Speculation should be identified as such.

DC 8 Provide at least four reasons which support the position that traditional classification and labeling schemes (e.g., mentally retarded, psychotic) are inadequate and often misleading for determining individual needs, proper placement, and appropriate intervention strategies.

DC 9 Define "mental retardation" using both the AAMD's and Marc Gold's (1979) definitions; compare and contrast the definitions and explain the program planning implications of each.

DC 10 Distinguish between the terms "incidence" and "prevalence" and compare incidence and prevalence figures for specified disabilities at different ages (e.g., infant, pre-school, school-aged, and adult mentally retarded).

DC 11 Specify the degrees of confidence that can be placed in current incidence and prevalence figures for specified exceptionalities and provide the rationale for the conclusions reached.

DC 12 Select a theory of learning and development and use it to explain why individuals with the same classificatory labels (e.g., severely retarded, epileptic) have widely dissimilar personalities, react differently to situations and progress at variant rates toward specified objectives.

DC 13 State the degree of confidence with which "experts" can predict a given exceptional individual's future accomplishments (e.g., academic achievement, career status, marriage, physical accomplishment) and provide research and authoritative opinion, as well as that taken from personal observations, to support the position taken.

DC 14 Use Smith and Neisworth's (1975) conceptualizations to distinguish among the terms "deviance," "deficit," and "handicap" and explain how a "deviance" is often unjustifiably transformed into a handicap by societal stereotypes and expectations, and how an objectively defined disability (e.g., loss of sight) may evolve into an unnecessary handicap.

DC 15 Explain what is meant by Hewett and Forness' (1977) concept that many exceptionalities or components of an individual's deviance are transitory and specify the implications of this for individual program planning (e.g., the verbal aggressiveness of a cerebral palsied adult may be transitory, but his spasticity is likely to be permanent).

DC 16 Describe, in a sequential fashion, the general process of and procedures involved in classifying an individual as developmentally disabled. Start from the initial suspicion that a problem exists.

DC 17 Explain the effects on both treatment and expectations for improvement of different professions giving dissimilar labels to individuals displaying the same symptoms (e.g., the psychiatrist may label the person as "psychotic" and the educator may label him as "disruptive").

DC 18 List the basic assessment instruments and procedures employed by specified professions for classifying persons as developmentally disabled and summarize the limitations of the instruments and procedures identified, with reference to research and/or authoritative opinion.

DC 19 Construct a chart identifying factors known to or presumed to contribute to the development and maintenance of specified disabilities and describe the basic procedures or intervention strategies currently employed for reducing, eliminating or precluding the effects of these factors.

DC 20 Distinguish between the behavioral and medical definitions for specified disabilities and illustrate both the utility and limitations of each definition with respect to the primary problems which frequently confront given residents.

DC 21 Trace the "typical" behavioral and emotional pattern(s) of families who discover their child is developmentally disabled and identify how this may add to or lessen the negative impact of the disability on the child.

DC 22 Define and give an example of each of:

(1) primary prevention
(2) secondary prevention
(3) tertiary prevention

DC 23 List and provide essential information about the causation, symptomatology, mortality, degree of involvement and treatment and/or prevention for 15 of the most common developmental disabilities.

## References for Definitions and Causes Competencies

Gold, M. W. An end to the concept of mental retardation: Oh, what a beautiful morning. *In Try Another Way Training Manual*. Austin, Texas: Marc Gold and Associates, 1979, p. 29.

Hewett, F. M., and Forness, S. R. *Education of exceptional learners* (2nd edition). Boston: Allyn and Bacon, Inc., 1977.

Smith, R. M., and Neisworth, J. T. *The exceptional child: A functional approach*. New York: McGraw-Hill Book Company, 1975.

Telford, C. W., and Sawrey, J. M. *The exceptional individual* (3rd edition). Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1977.

## 5. Group Process (GP)

### a. Goal

To know and effectively use the primary concepts of group processes to develop more satisfactory relationships with those involved in ALA's.

## b. Competencies

The Resident Advisor Trainee should be able to:

GP 1 Paraphrase and summarize the feelings expressed by a resident.

GP 2 Demonstrate the basic elements of physical attending as described by Egan (1975):

S - face the other person SQUARELY
O - adopt an OPEN posture
L - LEAN toward the other
E - keep good EYE contact
R - try to be "at home" or relatively RELAXED in this position

GP 3 Use a behavioral interview format, such as that described by Lazarus (1974), to ask questions that help the resident clarify feelings and issues.

GP 4 Use an "expressive vocabulary," such as that described by Egan (1975), to identify his/her feelings and emotions.

GP 5 Describe the significant nonverbal behavior of a resident and explain its importance.

GP 6 Verbally summarize the nonverbal signals and cues being emitted by a resident to the resident's and/or supervisor's satisfaction.

GP 7 Develop a set of guidelines for determining when self-disclosure is appropriate and effective.

GP 8 Use a set of guidelines to determine the effectiveness and appropriateness of an instance of self-disclosure.

GP 9 Accurately communicate understanding of a resident's feelings to his satisfaction (e.g., "You feel . . . because . . .").

GP 10 Develop a comprehensive list of behaviors that show genuineness and respect and conform to a recognized definition of each (e.g., Egan, 1975).

GP 11 Use the framework of an existing change model, such as Whelan's Planned Change Model for Personal Growth, to outline the steps involved in helping a resident formulate a plan for behavioral change.

GP 12 List questions that will help a resident to evaluate each step of his/her change plan as it is implemented.

GP 13 Provide a definition and give examples of successive approximation in accomplishing a resident's goal.

GP 14 Demonstrates the use of relaxation techniques to help residents deal with stress.

GP 15 Identify and demonstrate the steps involved in role playing as presented by a recognized resource, (e.g., Maier, Solem and Maier, 1976).

GP 16 State the issues in conflict to the satisfaction of the participating parties, given a conflict situation.

GP 17 Develop a list of strategies for conflict resolution, and explain why and when it is best to employ the various strategies.

GP 18 List the points of agreement and disagreement in a group to the members' and/or instructor's satisfaction in order to facilitate movement toward consensual decisions.

GP 19 List the rules of effective feedback as outlined by Hanson (1975) or Johnson (1972) or some other recognized source and demonstrate the use of the rules with residents and fellow RA trainees.

GP 20 Distinguish statements of fact from statements of feeling or opinion, from a given list of statements and/or observations of a group involved in problem-solving.

GP 21 Define the maintenance, task and process functions in a group and give examples of how these functions affect staff-resident interaction within a group home or apartment.

GP 22 Identify the norms that are present in an ALA and a program planning group.

GP 23 Define the phenomenon of "sub-grouping" and identify it as it takes place within a group.

GP 24 List the steps to effective problem-solving as described by a recognized source (e.g., Kaufman, 1976; or Napier and Gershenfeld, 1973).

GP 25 Specify the steps involved in effective decision making, as delineated by a recognized source (e.g., Johnson and Johnson, 1975; Napier and Gershenfeld, 1973).

GP 26 Explain and provide examples of how selective perception and self-imposed distortions can create barriers to problem-solving in an ALA.

GP 27 Identify Caplan's (1964) four developmental phases of crisis.

GP 28 Discuss how balancing factors (i.e., perception of the event, situation supports and coping mechanisms) effect one's equilibrium in a crisis.

GP 29 List and explain Raths' (1966) seven sub-processes of value development.

GP 30 Describe how Simon, Howe, and Kirschenbaum (1972) value clarification strategies can be used as a step in resolving conflicts arising from the clashing value systems of ALA staff and other community residents.

GP 31 List two major areas of uncertainty identified by Bennis and Shepard (1956) that present obstacles for valid communication.

GP 32 Use a general theory of group development (e.g., Bennis and Shepard) to give examples of how the issues of power, authority, group membership, group norms, and conflict impact on the residents and staff of an ALA.

GP 33 Develop and implement a plan for formulating house rules which:

(1) involves ALA residents
(2) is consistent with the concepts of normalization and dignity of risk
(3) conforms to Glasser's (1969) format for running class meetings

GP 34 Explain the following group roles in terms of the task, maintenance, and process functions in a group:

(1) information giver/seeker
(2) initiator
(3) direction giver
(4) summarizer
(5) coordinator
(6) harmonizer
(7) tension reliever
(8) standard setter
(9) active listener
(10) trust builder
(11) problem solver

GP 35 Explain a basic model of group communication which describes the basic conditions for successful communication and problem solving, and the characteristics of an effectively functioning group (e.g., as outlined by Andersen, 1974).

GP 36 Lead a brainstorming session which adheres to the four basic rules of brainstorming:

(1) adverse criticism is taboo
(2) "free-wheeling" is welcomed
(3) quantity of ideas is desired
(4) combination and improvement of ideas is sought

GP 37 Specify how language and memory factors often distort intended meaning and polarize problem solving groups.

GP 38 Identify and describe factors generally acknowledged to be responsible for individual behavior in small groups (e.g., reinforcement history, present needs, stereotyped images, individual fantasies, reference to external groups).

GP 39 Specify the actions that a group member can take to enhance the attractiveness and functioning level of a group charged with developing, implementing and monitoring an individual program plan.

GP 40 Identify basic factors which inhibit the free sharing of information and opinions in small group situations (e.g., factors which arouse defensiveness).

GP 41 List the primary reasons for resistance to change within small groups and detail the actions a group member can take to reduce resistance.

GP 42 Design inclusion activities to break tension and help members of a new or ongoing group get better acquainted.

GP 43 Define the components of effective group goals (e.g., coordination with individual goals, specificity, etc.) as delineated by Johnson and Johnson (1975), Napier and Gershenfeld (1973), or some other recognized source.

GP 44 Develop a list of questions to ask residents and resident advisors in order to identify group goals and the processes related to developing and maintaining goals.

GP 45 Describe the activities and principles which need to be adhered to in transforming aggregates of individuals into cohesive and effectively functioning professional teams and specify what he can do to assist a group he is involved with improve its effectiveness in reaching decisions and serving residents.

GP 46 Seek and utilize supervision from staff members, supervisors and faculty.

GP 47 Carry out self-assessments periodically, identifying strengths and areas needing further development.

GP 48 Exchange views, techniques, approaches and information with other professionals.

## References for Group Process Competencies

Andersen, M. A model of group discussion. In R. S. Cathcart and L. A. Samovar (Eds.). Small group communication: A reader. Dubuque, Iowa: William C. Brown Company, 1974.

Bennis, W. G. and Shepard, H. A. A theory of group development. Human Relations, 9, 414-438, 1956.

Caplan, G. Principles of preventive psychology. New York: Basic Books, 1964.

Egan, G. Exercises in helping skills: A training manual to accompany the skilled helper. Monterey, California: Brooks/Cole Publishing Company, 1975.

Glasser, W. Schools without failure. New York: Harper and Row, Publishers, 1969.

Hanson, P. G. Giving feedback: An interpersonal skill. In J. W. Pfeiffer and J. E. Jones (Eds.), The 1975 annual handbook for group facilitators. La Jolla, California: University Associates Publishers, 1975.

Johnson, D. W. Reaching out: Interpersonal effectiveness and self-actualization. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1972.

Johnson, D. W., and Johnson, F. P. Joining together: Group theory and group skills. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975.

Kaufman, R. Identifying and solving problems: A system approach. La Jolla, California: University Associates, Inc., 1976.

Lazarus, A. Annual Review & Behavior Therapy, Vol. II. Cyril Franks and Terence Wilson (Eds.). New York: Brunner/Mazel, 1974.

Maier, N., Solem, A. R., and Maier, A. The Role-Play Technique: A Handbook for Management and Leadership Practice. La Jolla, California: University Associates, 1976.

Napier, R. W., and Gershenfeld, M. Groups: Theory and experience. Boston: Houghton Mifflin Company, 1973.

Raths, L., Harmin, M., and Simon, S. Values and Teaching. Columbus, Ohio: Charles E. Merrill, 1966.

Simon, S. B., Howe, L. W., and Kirschenbaum, H. Values Clarification. New York: Hart, Inc., 1972.

Wheelan, S. The Planned Change Model for Personal Growth. Monograph, PEP Center, Temple University, 1979.

## 6. Human Development Competencies (HD)

### a. Goal

To understand the basic principles of human development at various ages and to apply these principles in providing ALA services.

### b. Competencies

The Resident Advisor Trainee should be able to:

HD 1 Identify the salient physical growth patterns occuring during major developmental periods (e.g., prenatal, infancy and early childhood, adolescence, and adulthood).

HD 2 Give an example of a genetic disease transmitted by a dominant gene and explain why there are no carriers of such diseases.

HD 3 Give an example of a genetic disease transmitted by a recessive gene and describe the risk to each child born to parents who are both carriers of such a disease.

HD 4 Explain how maternal characteristics existing prior to conception can affect the risk status of the unborn child (e.g., characteristics such as maternal age, prenatal care, nutrition and medical history).

HD 5 Construct a matrix illustrating how the occurrence of the following factors during pregnancy can affect the fetus: nutrition, illegal drugs, prescription drugs, over the counter drugs (e.g., aspirin), caffeine, alcohol, tobacco, X-rays, diseases such as venereal diseases, rubella and toxoplasmosis.

HD 6 Describe the effects on the newborn of drugs administered during childbirth and explain how these effects are thought to affect the process of emotional bonding between the mother and the infant.

HD 7 Describe the effects of maternal deprivation in animals and in humans (cf.) and explain what these findings tell us about the prerequisites (in the adult-infant relationship) for optimal cognitive, social and emotional development; assess the implications of the maternal deprivation research for institutionalization in general and for day care specifically.

HD 8 Explain what is meant by the "nature-nurture" controversy, with specific reference to the following areas: intellectual ability, language development and personality characteristics.

HD 9 Describe the interactionist viewpoint with regard to the nature-nurture controversy, and give an example of how an interactionist would explain the development of individual differences in (a) intelligence and (b) personality or temperament.

HD 10 Explain why findings of high concordance between parents and their children on a given variable do not necessarily imply a genetic basis for the variable.

HD 11 Highlight the essential differences between developmental characteristics and individual difference characteristics.

HD 12 Distinguish between the concepts of "critical period" and sensitive period and explain the implications of these concepts for rehabilitative intervention.

HD 13 Describe the course of cognitive development in terms of a specific theory and list several implications of the theory for the educational process (e.g., use Piagetian* theory to explain how knowledge is acquired, explain which abilities emerge during the major Piagetian stages and list several implications of Piagetian theory for educators).

HD 14 Identify and illustrate each of Freud's* psychosexual stages and explain why each stage is viewed as a "critical period" (i.e., critical for later development).

HD 15 List, define and give an example of three defense mechanisms which shows how each defense mechanism is a means of handling anxiety.

HD 16 Define the terms anxiety and fear and provide an illustration showing how they differ from each other.

HD 17 Describe the development of moral judgment and/or moral behavior in terms of cognitive developmental theory (Piaget or Kohlberg*) and Freudian theory.

HD 18 Criticize Kohlberg's approach to moral development in terms of (a) the empirical validity of his "stages" and (b) the implications for moral behavior.

HD 19 Describe how during the middle childhood years new demands for competence and mastery are placed on the child, in terms of (a) physical, (b) cognitive and (c) socio-emotional growth.

HD 20 Give three examples of how behavior principles can be applied to human development (utilizing the concepts of positive and negative reinforcement, extinction and partial reinforcement).

HD [illegible]1 Define the terms classical conditioning and instrumental conditioning and distinguish between the two by giving an example of a classically conditioned response and an instrumentally conditioned response.

HD 22 Distinguish between positive reinforcement, negative reinforcement, punishment and extinction.

HD 23 Explain what is meant by "partial reinforcement effect."

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*The theories of development followed by asterisks in this section are described in Vanden Zander's Human Development, New York: Knopf, 1978.

HD 24 List several short and long term negative effects of punishment.

HD 25 Define modeling or observational learning and give two examples of how modeling can affect the level of (a) prosocial behavior and (b) antisocial behavior.

HD 26 Use the social learning concept of modeling to explain why some observers have argued that parents who abuse their children tend to have been abused as children.

HD 27 Summarize the effects on children of different parenting styles (e.g., authoritarian, permissive and authoritative).

HD 28 Identify the age at which assigned sex roles are established, (i.e., become very resistant to change) and provide prominent evidence to support the age given.

HD 29 Explain why stimulus-response theory has been inadequate for explaining the development of language.

HD 30 List and illustrate the major stages of language development during the first three years of life.

HD 31 Explain the meaning of the phrase "understanding precedes production."

HD 32 Interpret a given IQ score by explaining where that score would lie within the general population's distribution of IQ scores and illustrate three major criticisms of such scores for making decisions for exceptional individuals.

HD 33 Distinguish between the term emotionally disturbed and learning disabled by (a) defining the primary characteristics of each, (b) listing the differences and (c) indicating possible areas of commonality.

HD 34 Describe three different theoretical approaches to the etiology and treatment of emotionally disturbed and learning disabled children (e.g., the biological, stimulus response, and psychoanalytic approaches).

HD 35 Explain the meaning and importance of "life span developmental psychology."

HD 36 Identify and describe the importance of the issue to be resolved in each of Erikson's* eight stages of psychosocial development.

HD 37 Illustrate how Erikson's concept of identity influences adolescents in the following areas: physical and sexual identity, vocational identity, social identity and self-concept.

HD 38 Describe the major growth patterns occuring during normal adolescence in the areas of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

HD 39 Explain the difficulties or obstacles encountered by adolescents with specified developmental disabilities in dealing with the normal problems of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

HD 40 Identify the additional obstacles encountered by a developmentally disabled adolescent in dealing with normal developmental difficulties, given a specific set of data. For example, how are difficulties relating to the opposite sex exacerbated by being cerebral palsied or epileptic.

HD 41 Distinguish between normal and abnormal adolescent difficulties and behavors in the areas of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

HD 42 Formulate the basic questions asked by normally maturing adolescents about themselves.

HD 43 Specify how the normal questions usually posed by typically maturing adolescents about themselves are infuenced by particular developmental disabilities, given a specific set of data.

HD 44 Explain the significance of the following consideration for exceptional individuals: adolescence is not only a function of age, but of cognitive and experiential maturity.

HD 45 Distinguish between adults and adolescents from the perspective of physical development and needs, the search for identity and independence, emotional stability, social and social-sexual development.

HD 46 Specify several common physical ailments of adulthood at various ages for specified disabilities.

HD 47 Describe the major stages of adulthood identified by recent research on adult males and provide a behavioral example indicative of each stage.

HD 48 Identify and evaluate the validity of four major beliefs concerning the living conditions, health and finances of the aged.

HD 49 Define the term "cloak of competence" (Edgerton, 1967) and predict particular problems that may develop with a specified developmentally disabled person who is engaged in compensating outside the ALA, given a specific set of data.

HD 50 Specify behavioral indices (e.g., laughter, grief, withdrawal) that a resident is having a problem outside of the ALA which may necessitate attention.

## References for Human Development Competencies

Edgerton, R. B. The cloak of competence: Stigma in the lives of the mentally retarded. Berkeley: University of California Press, 1967.

Vander Zanden, J. W. Human Development. New York: Knopf, 1978.

## 7. Individual Program Design, Implementation And Evaluation (IPDIE)

### a. Goal

To understand how to design, implement and evaluate programs for individual residents as a member of an interdisciplinary program planning and implementation team.

### b. Competencies

The RA Trainee should be able to:

IPDIE 1 Specify the primary concern(s) RAs should have with respect to diagnosis and individual program planning (e.g., "Will the program suggested likely have adversive second-order effects on the resident?").

IPDIE 2 List the responsibilities of the RA for program planning, monitoring and evaluation.

IPDIE 3 Present a rationale for fully involving the resident or his representative (e.g., surrogate parent) in formulating program objectives. Provide an example of how this was done.

IPDIE 4 State the purposes and advantages of interdisciplinary program planning meetings which involve the resident and/or his parents and representatives.

IPDIE 5 List three possible dangers of involving a resident and/or his parents in an individual program planning meeting and provide strategies for eliminating or substantially reducing these dangers.

IPDIE 6 List the rights of the resident with respect to the privacy of records, individual program planning and freedom of movement within the ALA program.

IPDIE 7 Conduct self to maintain the rights identified in IPDIE 6.

IPDIE 8 Describe and evaluate, vis-a-vis a set of standards, his (own) performance at an individual program planning meeting, given the opportunity to assume the role of an RA and a set of standards against which to compare his performance.

IPDIE 9 List criteria indicating that an interdisciplinary program planning meeting is necessary. Write a memorandum calling such a meeting and specifying the reasons.

IPDIE 10 Explain how the following individual program planning elements relate to each other: an assessment of a resident's strengths, weaknesses and needs; the interdisciplinary program planning conference; long term and short term objectives; intervention strategies; and, program evaluation and review.

IPDIE 11 Specify those individuals who should be involved in designing and refining a resident's individual program plan.

IPDIE 12 State criteria that should be applied for staffing individual program plan meetings; i.e., determining which professions and individuals within these professions should be invited to participate in the planning.

IPDIE 13 List the behaviors that should characterize the chairperson of an individual program plan meeting. Implement that role at such a meeting.

IPDIE 14 Define the responsibilities of each member of the program planning team to both the team and the planning process. Implement the role of the RA at such a meeting.

IPDIE 15 Explain why intervention plans and procedures should begin at the resident's level of functioning, and why they should not remain at that level.

IPDIE 16 State the purposes and benefits of an individual program plan and list and define the basic elements of such a plan.

IPDIE 17 Specify the kinds of data that are necessary for developing an initial program plan and specify sources for such data.

IPDIE 18 Unobtrusively observe a resident, describe his behavior in performance terms, and present quantitative and qualitative data to support any hypotheses formulated about the resident as a result of the observations.

IPDIE 19 List comprehensive criteria for prioritizing a resident's needs, and given a particular set of data, prioritize a resident's needs in a manner reflecting the criteria presented.

IPDIE 20 Contribute focused comments regarding resident needs, progress and program content, given a specific set of data. These comments should either elicit relevant information, contribute to problem solving, or engender conversation which contributes to a more complete explanation of the residents' needs and behavior.

IPDIE 21 List the advantages of placing time limits on long-term and short-term objectives.

IPDIE 22 Distinguish between long-term and short-term objectives, specify how they relate to each other, and provide examples of each which clearly demonstrate a high degree of relatedness.

IPDIE 23 Given specific data, set time limits for long and short-term objectives for a given resident. Provide a rationale for the limits set.

IPDIE 24 State and prioritize a set of long-term and short-term objectives adhering to Mager's (1975) format, given a specific set of data.

IPDIE 25 Draw conclusions from a given set of data about a resident; from those conclusions formulate long-term and short-term objectives, prioritize them, and establish strategies for implementation. Specify how the conclusions, objectives, and prioritization of the strategies is supported by the data.

IPDIE 26 Describe the essential components of an individual program plan, delineate responsibilities for the information needed, and indicate who is responsible for finalizing each of the components.

IPDIE 27 State why it is necessary for parties involved in implementing program objectives to know exactly what their responsibilities are and to explicitly agree to meet their responsibilities.

IPDIE 28 At a particular program planning team meeting, ensure that each team member can describe his/her responsibilities for the program under consideration, and obtain a commitment from each team member to execute the agreed-upon function(s).

IPDIE 29 Describe the primary functions and responsibilities of those professions usually involved in the diagnosis and case management of residents.

IPDIE 30 Define the basic terms used by professions critical to the development and implementation of an individual program plan, given a list of core terms.

IPDIE 31 Describe the basic data gathering procedures used by specified professions usually involved in individual program planning and management, given a list of procedures categorized by profession.

IPDIE 32 List the basic questions specified professions should be prepared to answer, vis-a-vis the functioning levels and needs of residents, (e.g., psychology: are there severe emotional problems; would he likely profit from XYZ therapy?).

IPDIE 33 Pose questions to professionals involved with planning and implementing individual program plans which result in more information and clarity about what is being said at individual program planning meetings.

IPDIE 34 Explain a basic model of group communication which describes the basic conditions for successful communication and problem solving, and the characteristics of an effectively functioning group (e.g., as outlined by Andersen, 1965).

IPDIE 35 Lead a brainstorming session which adheres to the four basic rules of brainstorming (adverse criticism is taboo, "free-wheeling" is welcomed, quantity of ideas is desired, combination and improvement of ideas is sought), given a problem to be solved.

IPDIE 36 Identify and describe factors frequently acknowledged to contribute to the behavior of individuals in small groups (e.g., reinforcement history, present needs, sterotyped images, individual fantasies, external referrent groups).

IPDIE 37 Specify the actions that a group member can take to enhance the attractiveness and functioning level of a group charged with developing, implementing and monitoring an individual program plan. (Measures of attractiveness might include better attendance, more eye contact with the speaker, an increase in the number of positive comments about the group and its task; functioning level may be measured by the number of problems solved and the quality of the solutions.)

IPDIE 38 Identify and describe the basic difficulties a given individual program planning group is having communicating effectively, cite the reasons for the difficulties, and devise ameliorative strategies.

IPDIE 39 Explain and provide examples of how language and memory factors often distort intended meanings and polarize problem solving groups.

IPDIE 40 Define those defense arousing factors identified by Gibb (1961) which inhibit the free sharing of information and opinions in small group situations and provide examples of each.

IPDIE 41 Define those factors identified by Gibb (1961) which support the free and open exchange of information and opinions and provide examples of each.

IPDIE 42 List generally acknowledged reasons for resistance to change within small groups and detail the actions group members can take to reduce such resistance.

IPDIE 43 Explain the difference between "consensus" and "compromise" and provide descriptions of situations that are appropriate and inappropriate for both.

IPDIE 44 Lead an interdisciplinary group to a consensus program plan for working with an individual resident, given specific role playing scripts for each participating "professional" and specific data about the resident.

IPDIE 45 Describe the appeal steps an individual program planning team member should take when disagreeing with the data presented about a resident, the conclusions reached or the recommendations made. These steps should not violate those recommended in the policy manual for ALA staff at the trainee's practicum site.

IPDIE 46 Diagram the informal appeal and due process procedures parents, clients or other interested parties should follow when disagreeing with an individual program plan.

IPDIE 47 List a series of questions and procedures for ascertaining the effectiveness of particular intervention strategies with individual residents. Using the list generated, evaluate the effectiveness of an intervention strategy with particular residents.

IPDIE 48 Specify the probable reasons a resident does not achieve established instructional objectives, given a specific set of data about an actual resident.

IPDIE 49 State an appropriate plan of action when residents are not meeting established short term or long term objectives. Implement the plan with a given resident.

IPDIE 50 Observe a program planning meeting in an unobtrusive fashion and use a given set of standards to evaluate its effectiveness in developing an individual program plan; justify the conclusions reached.

## References for Individual Program Design, Evaluation, and Implementation Competencies

Andersen, M. "A model of group discussion." In R. S. Cathcart and L. A. Samovar (Eds.), Small group communication: A reader (2nd edition). Dubuque, Iowa: William C. Brown Company, 1974.

Gibb, J. R. "Defensive communication." In R. S. Cathcart and L. A. Samovar (Eds.), Small group communication: A reader (2nd edition). Dubuque, Iowa: William C. Brown Company, 1974.

Mager, R. F. Preparing instructional objectives (2nd edition). Belmont, California: Fearon Publishers, Inc., 1975.

## 8. Instructional Analysis (IA)

### a. Goal

To teach residents how to master complex tasks.

b. Competencies

The RA Trainee should be able to:

IA 1 Analyze the interaction of two or more persons or an instructional situation with reference to a structured theory of behavior change (e.g., H. C. Quay's, 1968 stimulus, response, and reinforcement model).

IA 2 Analyze a series of tasks required of a resident using a prominent task analysis procedure (e.g., Gold, 1976, 1977; Hakim, 1974; Johnson, 1967; or Stoddard and Gibson, 1977).

IA 3 Specify how to teach given tasks using the techniques of forward and backward chaining and total task presentation.

IA 4 Teach a resident to perform a given task using the principles of forward and backward chaining and total task presentation.

IA 5 Select and use reinforcers and reinforcement schedules for a given resident learning to perform a specified task that is new to him. Evaluate how well the resident has larned the task and the appropriateness of both the reinforcer and schedule.

IA 6 Select, use, and evaluate the effectiveness of a reinforcer(s) and a reinforcement schedule for a resident who needs to maintain a newly acquired behavior.

IA 7 Explain to significant individuals involved with the resident how specific tasks should be broken down and presented to the resident, in a manner that is clear, comprehensible and translatable into action.

IA 8 Demonstrate to other Trainees how to fractionalize a complex task into manageable components to facilitate resident learning.

IA 9 Teach a resident how to perform a complex task by analyzing the task into components which the resident can do, having the resident sequentially integrate all the components into a whole, and perform the task himself.

IA 10 Select appropriate reinforcers and reinforcement schedules for a resident learning a particular targeted behavior so the resident performs the desired behavior at an acceptable rate without artificial or scheduled reinforcement, in a variety of environments.

## References for Instructional Analysis Competencies

Gold, M. W. "Task analysis of a complex assembly task by the retarded blind." Exceptional Children, 1976, 43, 78-84.

Gold, M. W. Try another way. Sacremento, California: The California Project, 1977.

Hakim, C. S. "Task analysis: One alternative." Academic Therapy, 1974, X, 2, 201-209.

Johnson, D. J. "Educational principles for children with learning disabilities." Rehabilitation Literature, 1967, 28, 317-322.

Stoddard, D. W., and Gibson, D. The project SKILLS general task analysis and electronic assembly training manual. Washington, D.C.: HEW, Developmental Disabilities Office, 1977.

### 9. Medically Complex and Multiply Handicapped (MCMH)

#### a. Goal

To provide the resident advisor with an opportunity to develop specialized skills through an in depth study of the special needs of sensory-motor impaired and multiply handicapped residents beyond the generic core of resident advisor competencies.

#### b. Competencies

The Resident Trainee should be able to:

MCMH 1 Recognize common physical distress signals for given medical problems manifested by severely and/or profoundly medically complex individuals who have little or no communicative ability and specify a preferred course of action to attend to those physical distress needs.

MCMH 2 Identify the nature, characteristics and portions of selected foods which are required or prohibited on diets of developmentally disabled individuals with commonly associated medical conditions requiring special diets (e.g., diabetes).

MCMH 3 Demonstrate medically recommended procedures for recording the following:

(1) temperature (oral, rectal and under the arm)
(2) pulse rate
(3) blood pressure
(4) respiration rate

| | |
|---|---|
| MCMH 4 | Recognize characteristic symptomatic danger levels of high/low temperature, pulse rate, blood pressure and respiration rate. |
| MCMH 5 | List factors which contribute to skin tissue breakdown and deterioration. |
| MCMH 6 | Given relevant case data, design an appropriate toileting program for individuals with specified difficulties (e.g., physical, profound retardation). |
| MCMH 7 | Describe the proper use of and proper care for bedpans. |
| MCMH 8 | Identify environmental and personal conditions which lead to diseases and infection difficulties associated with incontinence. |
| MCMH 9 | Identify appropriate remedial steps necessary for the alleviation of incontinence. |
| MCMH 10 | Provide a list of measures to prevent incontinence. |
| MCMH 11 | Identify the physical components of the human respiratory process. |
| MCMH 12 | Explain the organic functioning of the human respiratory system. |
| MCMH 13 | Demonstrate the techniques of respiratory drainage and mucus dispersal. |
| MCMH 14 | Describe the effects of gravitational influences associated with specified associated medical conditions (e.g., asthma, hayfever, allergies, croup). |
| MCMH 15 | List remedial procedures appropriate for alleviation of discomfort associated with respiratory difficulties. |
| MCMH 16 | List the common symptomatic signs of deafness and blindness in infants. |
| MCMH 17 | Demonstrate fundamental knowledge of basic sign language and brail. |
| MCMH 18 | Utilize communication boards with deaf or autistic residents who cannot communicate through other means. |
| MCMH 19 | Identify the basic components of the human digestive system. |
| MCMH 20 | Describe the functioning of the human digestive system. |

MCMH 21 Describe the gravitational effects on the digestive process.

MCMH 22 Identify the elements of proper posturing for the feeding process and demonstrate proper positioning with specified individuals.

MCMH 23 Identify factors which lead to difficulties in rumination (chewing) and procedures for ameliorating such difficulties.

MCMH 24 List the major principles of:

(1) body alignment
(2) positioning
(3) range of motion
(4) restraints

MCMH 25 Demonstrate the application of the major principles of:

(1) body alignment
(2) positioning
(3) range of motion
(4) restraints

MCMH 26 For a specific individual, demonstrate various appropriate bathing techniques including:

(1) holding and positioning
(2) use of special equipment where applicable

MCMH 27 Demonstrate the proper use of adaptive equipment, including:

(1) protective and posture equipment
(2) prosethetic and mobility equipment
(3) skills enhancing equipment

MCMH 28 Identify three occasions when special adaptive equipment is:

(1) necessary
(2) unnecessary

MCMH 29 Describe appropriate observational techniques vis-a-vis:

(1) seizure observation and recording
(2) affects of medication and recording

MCMH 30 Describe access problems of impaired persons, with regard to both physical and psychological barriers.

MCMH 31 Identify appropriate steps to be taken to remove physical and psychological barriers in the ALA setting.

MCMH 32 List the major components of the central and peripheral nervous systems.

MCMH 33 Explain the principal function and functional interrelationships among the major components of the central and peripheral nervous systems.

MCMH 34 Explain how the functioning of the major components of the central and peripheral nervous systems and their interrelationships are impaired in specified developmentally disabling conditions.

MCMH 35 List the major principles of hygiene to be observed in food preparation; be inclusive enough to insure food safety.

MCMH 36 Identify five medical conditions associated with developmental disabilities which require special diets.

MCMH 37 Recognize the nutritional value of dietary supplements, multiple vitamins and vitamin complexes.

MCMH 38 List appropriate usages of dietary supplements, multiple vitamins and vitamin complexes under specified conditions.

## 10. Normalization (NOR)

### a. Goal

To understand the concept of normalization and know how to apply its principles.

### b. Competencies

The RA Trainee should be able to:

NOR 1 Operationally define respect and list two ways in which exceptional people are commonly but unintentionally treated with disrespect.

NOR 2 Identify five serious misconceptions the general public has about specified developmentally disabled ALA residents and delineate at least three strategies for effectively reducing or eliminating the misconceptions cited.

NOR 3 Describe three discrete ways staff can motivate recalcitrant residents to become involved in home and community activities; provide justification for the motivation strategies described.

NOR 4 Specify common re-entry problems clients have in moving from institutions to ALAs and delineate strategies for reducing or eliminating the re-entry problems identified.

NOR 5 Describe three documented effects prolonged (one or more years) institutionalization has on the development of exceptional individuals.

NCR 6 Enumerate and describe three effects of labeling which are supported by research or authorative opinion.

NOR 7 Describe the similarities and differences between two authorative definitions of normalization (e.g., Bank-Mikkelson, Nirje, Wolfensberger).

NOR 8 List the major reasons provided by a major authority (e.g., Bank-Mikkelson, Nirje, Wolfensberger) for advocating adherence to the principle of normalization.

NOR 9 Cite three authorative criticisms of the normalization principle and provide reasons for supporting or rejecting these criticisms.

NOR 10 Provide two examples of how the normalization principle has been misused or misinterpreted. Justify the selection of the examples given.

NOR 11 Describe the major components of the normalization principle delineated by Wolfensberger (1972).

NOR 12 List criteria for distinguishing between more and less restrictive environments and rank five given settings in terms of restrictiveness.

NOR 13 Diagram Deno's (1970) "cascade" concept of "least restrictive environment" and specify what criteria and procedures would be appropriate for moving an individual from one level to another.

NOR 14 Discuss how an ALA may subtly encourge resident dependency and restrict opportunities for maximal development.

NOR 15 Explain what is meant by a "self-fulfilling prophecy" and provide two examples of how expectations can influence both resident and staff behavior and the opportunities for maximum development.

NOR 16 Write an individual habilitation plan for reintegrating an ALA resident individual into the community, given specific diagnostic data. The plan should specify how appropriate community resources (e.g., agencies) should be involved and how progress will be evaluated.

NOR 17 From direct observation, identify six dependency-producing practices in one or more ALAs and list ways that are likely to be effective in ameliorating them. Implement one of these ameliorative procedures in one or more ALAs and evaluate the results obtained.

NOR 18 Contrast the legal rights of residents to those of individuals who have not been classified as developmentally disabled and explain how an ALA may impinge on the rights of residents.

NOR 19 Define and discuss the responsibilities ALA residents need to assume when exercising particular rights.

NOR 20 Define "deviancy image" and explain how it relates to expectancies others have for ALA residents and the opportunities provided for maximal development.

NOR 21 List two subtle "deviancy images" attached to goodwill gestures such as donated clothes, rent-free buildings and charity-welfare funding streams. Use Wolfensberger's definition of "deviancy image" as a guideline.

NOR 22 Explain what Wolfensberger means by the "dignity of risk" and provide an illustration of how it can enhance a resident's life and an example of its misuse.

NOR 23 Provide illustrations of how normalization should affect dress, rhythm of day, work, rights and method of address, given a specific set of data about residents and the ALA in which they reside.

NOR 24 Use a particular theory of attitude development to explain the development of attitudes toward specified exceptionalities.

NOR 25 Describe an attitude toward a specified disability that has had a negative effect on individuals within that category and present a strategy that would likely be effective in reducing or eliminating the attitudes specified.

NOR 26 Explain and provide an example of how the social attitudes of majority groups influence the nature and quality of services for minority groups.

NOR 27 Summarize the arguments for and against the statement, "Comprehensive human services for exceptional individuals are a right and not a privilege."

NOR 28 Given a description of a particular ALA, its staff, and the opportunities for development available to residents, specify where within the continuum of "least restrictive environments" it should be placed.

NOR 29 Summarize the arguments for and against the statement "Residents should be involved in the formulation and evaluation of exit criteria affecting them."

NOR 30 Summarize the historical and philosophical reasoning providing the impetus for normalization.

NOR 31 List three implications of employing Gold's concept of a basically intact system vs. a non-working system with some intact parts (Board of Trustees of the California State University, 1978).

NOR 32 Using Smith and Neisworth's (1975) definitions, distinguish between deviance, disability and handicap and explain the importance of distinguishing between these concepts.

NOR 33 Provide two examples specifying how particular names and labels (e.g., "retarded," "crippled") commonly applied to disabled persons stigmatizes these individuals, affects their behavior, and affects the manner in which the public typically responds to persons with these labels.

NOR 34 List three unfavorable meanings which are commonly associated with the word "handicapped" and are usually hidden.

NOR 35 Using Smith and Neisworth's (1975) conceptualization of "handicap," provide an example of how utilization of the word with reference to a particular individual may result in self-fulfilling prophesies and diminished opportunities for new experiences.

NOR 36 Identify facets of behavior, situations, or appearance that signal deviance and develop strategies for reducing or eliminating the negative attention arising from these signals, given a specific set of data.

NOR 37 Given descriptions of two groups, list those signs that clearly indicate that one group is composed of exceptional people.

NOR 38 Distinguish between normalization as a means and as an end and provide a rationale for considering normalization as both a means, an end, or both.

NOR 39 Distinguish between social involvement in a community and being limited to physically "living" in an ALA or any other community program (e.g., foster home).

NOR 40 Given diagnostic data, describe the services needed by an ALA resident and his family to effectively function:

(1) at home
(2) at school
(3) in the community
(4) at work

NOR 41 Describe and evaluate the availability of generic and specialized services needed by individuals with particular disabilities and/or their families, in the community in which practicum occurs.

NOR 42 Explain the importance of social integration and provide a plan to socially involve an individual resident in a community-based activity.

NOR 43 Locate an appropriate site for an ALA using normalization standards as guidelines (e.g., proximity to physical resources), given data describing the residents.

NOR 44 Present a plan for establishing an ALA in a community that would evoke minimum attention to the ALA and its residents, given a specific set of data.

NOR 45 Describe how the principle of normalization may be applied to therapeutic intervention (e.g., the selection of reinforcers used in a behavior management strategem).

NOR 46 Specify when a highly prosthetic environment (e.g., specialized toilets, ramps, textured lines on walls) is necessary and the precautions which should be taken to reduce the visibility of the protheses.

NOR 47 Specify an argument for and against using culturally unnatural and/or artificial intervention strategems or prosthetic systems and devices for meeting client needs (e.g., systematically using food instead of verbal praise alone to foster a desired behavior or using a specially equipped automobile with a special license designating an exceptional individual).

NOR 48 Identify how selected programs and facilities for developmentally disabled individuals violate the principles of normalization; explain a strategy for reducing the disparities noted without adversely affecting the clientele.

NOR 49 Given data on a particular community, outline the major obstacles to the physical and social integration of residents, a strategy which appears particularly appropriate for reducing resistance to integration, and the resources needed to implement the strategy.

NOR 50 Procedurally detail what residents have to do to access particular generic services (e.g., what would a resident have to do to avail himself of employment counseling or to obtain services from a private physician).

NOR 51 After observing in a particular community describe prominent community attitudes and behaviors toward exceptional individuals which need to be modified to foster successful resident adjustment.

NOR 52 Explain how Wolfensberger's concept of normalization might be beneficially applied in preparing specified exceptional individuals for success in the community.

NOR 53 Identify a practicum site resident who is not leading as satisfying or normal a life as possible and present a realistic plan for making his life more satisfying or normal.

NOR 54 From the direct observation of a particular resident, list characteristic behaviors which are age-appropriate and behaviors which are not and present a strategy for eliminating one or more age-inappropriate behaviors.

NOR 55 Identify a negative effect a community is having on a particular resident and present a strategy for assisting the resident in reducing or coping with the effect; include indices for ascertaining the effectiveness of the strategy.

NOR 56 Describe how specified community resources should be used to facilitate maximal growth and development for residents (e.g., business, social and rehabilitative agencies).

NOR 57 Enumerate the criteria for eligibility to access specified community services needed by residents (e.g., what is the criteria for receiving training from vocational rehabilitation?).

NOR 58 Develop a series of activities to make exceptional individuals more aware of local services and opportunities and more apt to involve themselves with those identified. Implement a specified number of these activities.

NOR 59 Describe two strategies for motivating particular residents to discover and utilize community-based generic services for recreation and leisure time activities.

NOR 60 Enumerate two ways in which residents of a particular ALA and members of the general public can increase positive interaction with each other, given at least two months practicum experience in the ALA and the general standard that the increased involvement will not violate the rights of residents, including the right of privacy.

## References for Normalization Competencies

Bank-Mikkelson, N. E. "Model service models: A metropolitan area in Denmark-Copenhagen." In R. B. Kugel and W. Wolfensberger (Eds.). Changing patterns in residential services for the mentally retarded. Washington, D.C.: President's Committee on Mental Retardation, 1969.

Bank-Mikkelson, N. E. "Misconceptions on the principle of normalization," FLASH on the service for the mentally retarded, III. Copenhagen: The Personnel Training School, 1978, pp. 40-47.

Board of Trustees of the California State University. Way to go. Baltimore, Maryland: University Park Press, 1978.

Deno, E. N. Special education as developmental capital. Exceptional Children, 1970, 37, 229-237.

Nirje, B. "The normalization principle and its human management implications." In R. Kugel and A. Shearer (Eds.). Changing patterns in residential services for the retarded. Washington, D.C.: President's Committee on Mental Retardation, 1976.

Smith, R. M., and Neisworth, J. T. The exceptional child: A functional approach. New York: McGraw-Hill Book Company, 1975.

Wolfensberger, W. "A new approach to decision-making in human management services." In R. B. Kugel and W. Wolfensberger (Eds.). Changing patterns in residential services for the mentally retarded. Washington, D.C.: President's Committee on Mental Retardation, 1969.

Wolfensberger, W. The principle of normalization in human services. Downsville, Ontario: National Institute on Mental Retardation, 1972.

Wolfensberger, W., and Glenn, L. Program analysis of service systems (PASS 3). Downsville, Ontario: National Institute on Mental Retardation, 1975.

## 11. Problem Solving (PS)

### a. Goal

To describe and effectively employ a systematic process for solving problems.

### b. Competencies

The RA Trainee should be able to:

PS 1 Describe the elements of a systematic problem solving process (e.g., problem identification, problem definition, generation of alternatives, evaluation of alternatives, selection of a solution, implementation, incorporation of an evaluation plan and adjustive mechanism).

PS 2 Detail, in a step-by-step fashion, how a particular specified problem solving procedure can be used to identify and resolve a problem, given a particular set of data.

PS 3 Lead a small group of peers in identifying and resolving a problem, given a particular set of facts.

## 12. Program Maintenance (PM)

### a. Goal

To enable the resident advisor to assist in the design and execute the delivery of the day-to-day ALA program and interface with other community-based services.

### b. Competencies

The Resident Trainee should be able to:

PM 1 Describe the purpose, content, use and/or reporting procedures of the following documents as shown in the 1978 OMR implementation packet:

(1) individual program plan
(2) life management plan
(3) intake and proposed service plan
(4) provider personnel policies and procedures manual
(5) county-provider contract
(6) program provider agency monthly population report
(7) implementation procedure worksheet
(8) vacancy reports
(9) unusual incident/death report
(10) fire report
(11) county and regional checklists of required infile documentation

PM 2 Locate and prepare a summary of the most significant events in at least two ALA residents' case histories, including relevant social, education, vocational and psychological reports. Do it in a manner which protects resident's confidentiality.

PM 3 Given ALA budget data, develop a model petty cash account and a plan for its implementation which appropriately includes ALA residents and is consistent with practicum agency and state fiscal guidelines.

PM 4 Given ALA budget data, develop a model food account and a plan for its implementation which appropriately involves ALA residents and is consistent with practicum agency and state fiscal guidelines.

PM 5 Given client case data, develop a plan for monitoring ALA residents' personnel accounts (saving and checking), which appropriately involves ALA residents and is consistent with practicum agency and state guidelines.

PM 6 Develop a scheduling system in which ALA residents can become actively involved and which insures maintenance of housekeeping tasks, external appointments and program activities.

PM 7 Given sample case information, correctly fill out an Unusual Incident Report and a Fire in CLA (ALA) report as shown in the OMR implementation packet (1978).

PM 8 Given the requisite data, write a sample menu plan which includes three nutritionally balanced meals per day over a one-week period that (a) utilizes the four basic food groups, (b) shows variety and is appealing, (c) demonstrates economy by using comparative shopping techniques and store coupons, (d) is within the given food budget and (e) is supported by a detailed shopping list.

PM 9 Enumerate the signs to look for to recognize when fruits, vegetables, meat and dairy products are fresh.

PM 10 Enumerate the signs to look for to identify spoiled foods as discussed by the Life Project.

PM 11 Identify at least 15 shopping hints to aid in making economical food choices, including hints on choosing foods, alternative food choices and standard portions.

PM 12 Specify the guidelines for safe food handling and storage as discussed in the Michigan Provider Training Manual.

PM 13 Identify the conditions and proper procedure for starting a weight control program.

PM 14 List the seven techniques for successful weight loss given by the Life Project.

PM 15 Explain the importance of exercise in terms of physical development, group interaction and social integration.

PM 16 Identify under what circumstances exercise should be approached with caution.

PM 17 Given case data, design an individual exercise program for an ALA resident which involves physical development, group interaction and social integration.

PM 18 List three causes of constipation and the conditions and procedures required for administering enemas, laxatives and suppositories.

PM 19 Identify three factors which promote natural regularity.

PM 20 List the steps to take to insure good oral health.

PM 21 Specify the signs of dental disease (e.g., as listed by the Michigan Provider Training Manual, 1974).

PM 22 List the guidelines for good personal hygiene in the care of the skin, nails, hair, scalp, menstrual process and genitals.

PM 23 Identify the signs to look for to recognize head lice, body lice and scabies.

PM 24 Specify guidelines for reporting a suspected illness to a physician.

PM 25 List the information necessary for supervising the administration of medicines.

PM 26 Enumerate the guidelines for giving and measuring medicines.

PM 27 Given a case record summary, identify the following medically relevant information needed by the resident advisor:

(1) latest exam dates (e.g., dental, physical, gynocological, etc.)
(2) dates for next annual or follow-up exams
(3) immunization record and shot due dates (children)
(4) summary of relevant medical history including seizures, special diets, medications, unusual incidents, and allergies

PM 28 Specify how one should respond to epileptic seizures.

PM 29 Specify the usual symptoms of and treatment for diabetes.

PM 30 Describe the general causes, symptoms, and procedures for the emergency treatment of diabetic coma and insulin shock.

PM 31 Describe the precautions one should take in using specified drugs which are commonly used.

PM 32 List the possible side effects of specified drugs in terms of their impact on resident functioning and ALA programming (e.g., effect on bowel movements, temperament, speech, orientation, etc.).

PM 33 List the basic first aid supplies needed to treat injuries in the home.

PM 34 Demonstrate the following first aid procedures:

(1) cardiopulmonary resuscitation
(2) artificial respiration
(3) the Heimlich maneuver

PM 35 Describe the emergency procedures in applying first aid for burns, broken bones, shock, bleeding, eye injuries and poisoning.

PM 36 Enumerate potential hazards in and around the home and specify safety procedures which may prevent many common household injuries (i.e., poisoning, falls, burns and cuts).

PM 37 Outline the rules for proper handling and storage of flammable and poisonous materials.

PM 38 Describe the proper means for operation and maintenance of electrical appliances and other electrical equipment (i.e., extension cords, fuses, etc.).

PM 39 Specify the guidelines for "toy safety" regarding childrens' toys.

PM 40 Develop emergency plans for the following situations:

(1) fire
(2) medical trauma
(3) behavioral outbursts
(4) rape and abuse

PM 41 Describe the types and appropriate uses of standard fire extinguishers in the home.

PM 42 Assist the Base Service Unit and/or Individual Program Plan team to locate and access the following services:

(1) medical - including dental, general practice, GYN, specialists when needed
(2) counseling - including vocational, psychological, sex and family planning
(3) vocational - assessment, training, and placement
(4) education - assessment and placement in least restrictive setting, design of IEP

PM 43 Where applicable, list the location, eligibility requirements and basic services provided by the following organizations in the training locale:

United Cerebral Palsy Association, Association for Retarded Citizens, Federation for the Blind, Association for the Deaf, Epilepsy Foundation of America, Easter Seal Society, Society for Autistic Children

PM 44 Where applicable, list the nearest location of the following community facilities:

YMCA, YWCA, JYC, public recreational facilities (e.g., swimming pool, parks, libraries), movies, bowling alley, golf, church groups, sporting clubs/teams, restaurants, retail shopping center and laundromat.

PM 45 Identify and locate volunteer resources affiliated with public and private community organizations in the local community.

PM 46 Assess the recreational skills and interests of the residents in a particular ALA.

PM 47 Given case record data on a resident, enumerate age-appropriate and developmentally appropriate recreation and leisure time activities that the resident is likely to be interested and successful in.

PM 48 Describe at least three different levels of play.

PM 49 Given case record data, describe how two common recreational activities (e.g., ball games, table games) may be adapted for use by ALA residents who otherwise could not fully participate in such activities. Modifications should be consistent with the concepts of "normalization" and "dignity of risk."

PM 50 Assist recreational personnel in planning and implementing recreational and leisure time activities for particular residents.

PM 51 Describe the importance of recreation and leisure time activity to physical and emotional health and social development.

PM 52 Specify how recreation and leisure time activity can help facilitate the goals of normalization for developmentally disabled citizens.

PM 53 List adult education classes given at high schools and community agencies which many developmentally disabled citizens could successfully participate in.

PM 54 Design a plan for housekeeping tasks which:

(1) integrates program plan goals of residents
(2) shows a rotation of everyday home maintenance tasks (e.g., cleaning, laundering, etc.)

PM 55 Describe the operation and maintenance procedures for common major appliances.

PM 56 Describe the basic operation and maintenance procedures for common home heating and air conditioning systems.

PM 57 Specify the procedures for reporting and contracting for home repairs as outlined by the ALA practicum provider.

PM 58 List the basic tools which should be included in a home "tool box."

PM 59 Identify the basic hardware items which are useful for fastening and hanging items in the home.

PM 60 Identify adaptive gigs and devices which can facilitate more independent performance of home maintenance tasks for physically and sensory impaired residents (e.g., cooking, cleaning, mobility in the home).

PM 61 Describe a strategy to facilitate informal social interactions between ALA staff and residents and neighbors.

PM 62 Specify how formal presentations at community meetings can facilitate or impede acceptance of an ALA program and its residents.

PM 63 Outline how the media can work to change myths about the developmentally disabled and increase acceptance of ALAs in the community.

PM 64 Formulate responses to the following community concerns which will serve to lessen or eliminate common fears or misconceptions regarding the developmentally disabled living in the community:

(1) property values will go down
(2) ALA residents are sexually aggressive
(3) ALA residents carry contagious diseases
(4) ALA residents engage in bizarre behavior
(5) ALA residents pose a fire-hazard
(6) ALA residents pose a threat to the safety of neighbors, especially women and children

PM 65 Formulate responses to the following questions concerning ALA programs which the resident advisor may encounter in the community:

(1) What is the matter with those (ALA residents) people?
(2) Is a group home some kind of commune?

(3) Who pays for this ALA? Why should the taxpayer support this program?
(4) Why aren't these people in an institution?

PM 66 Observe, record and assess an ALA resident's social interaction skills.

PM 67 Develop strategies for improving inappropriate social behavior (e.g., hugging strangers) and withdrawn social behavior (e.g., avoidance of eye contact) which will facilitate increased socialization and community acceptance.

PM 68 Given case data concerning an autistic adult, develop an age-appropriate socialization plan which:

(1) builds tolerance for physical contact
(2) provides a foundation for communication with others
(3) develops the residents nonverbal socialization skills (e.g., appropriate smiling, posture, etc.)

PM 69 Provide a strategy for instructing ALA residents how to form intimate relationships with others including members of the opposite sex

PM 70 Given a resident in a practicum setting, assess and then develop a plan to improve the following social skills:

(1) manners and attitudes
(2) respect for rights and property of others
(3) making and keeping appointments
(4) recognizing offensive behavior in self and others
(5) conversation
(6) personal space
(7) authority and intimacy in relationships in the ALA, workshop, job, school and community

## References for Program Maintenance Competencies

*Life Project*, Harry A. Waisman Center on Mental Retardation and Human Development, University of Wisconsin-Madison. California: Standfield House, 1976.

*Michigan Adult Foster Care Provider Training Manual*. Lansing, Michigan: Michigan Department of Mental Health, DDS Publication 260 (7-75), 1974.

*Office of Mental Retardation Implementation Packet (Draft)*, Department of Public Welfare, Harrisburg, Pennsylvania, 1978.

## 13. Severely and Profoundly Impaired Track (SPI)

### a. Goal

To exhibit knowledge of and skill with those concepts which are particularly relevant to working with the severely and profoundly impaired.

### b. Competencies

The RA Trainee should be able to:

| | |
|---|---|
| SPI 1 | Define mental retardation, levels within the term and cite prevalence figures for each level. |
| SPI 2 | Identify criteria by which individuals are categorized as severely and profoundly impaired. |
| SPI 3 | State how the principle of "least restrictive environment" should be applied to the severely and profoundly impaired. |
| SPI 4 | Describe the basic content areas that should be included in programming efforts for the severely and profoundly impaired. |
| SPI 5 | List five journals which will provide information through articles, book reviews, ads, etc. which will help in designing programs and services for the severely and profoundly impaired individuals. |
| SPI 6 | Describe the relevance of existing developmental, recreational and vocational programs for individuals with severe and profound impairments living in residential facilities. |
| SPI 7 | Identify assessment procedures, formal and informal, that allow for identification of entering skills in activities of daily living for the severely and profoundly impaired. |
| SPI 8 | Identify the strengths and weaknesses of a severely involved individual and incorporate these into an individual program plan, given specific information about a resident. |
| SPI 9 | Identify common drugs used with the severely and profoundly impaired and be able to locate literature relating to the effects and side effects of the drugs. |
| SPI 10 | Describe, specify, praise and ignore strategies as basic elements of resident management. |

SPI 11 Identify overcorrection procedures and list the conditions under which overcorrection should be used in managing the behavior of the severely and profoundly impaired.

SPI 12 Operationally define, measure and chart behavior using permanent products, frequency, rate, time sampling, interval and/or duration methods.

SPI 13 Describe techniques to teach new behavior using shaping and/or fading procedures.

SPI 14 Define and implement techniques of punishment, time-out, extinction, differential reinforcement of other behavior, and responses cost.

SPI 15 Define and implement techniques of positive and negative reinforcement.

SPI 16 Describe five prompting procedures used with the severely and profoundly impaired.

SPI 17 Outline common correction procedures used in skill training with the severely and profoundly impaired.

SPI 18 Describe procedures to identify and/or establish effective reinforcers for the low-functioning.

SPI 19 Name four modifications that can be made to pencils, pens, brushes, etc. to facilitate writing, drawing, etc. for individuals with severe motor handicaps.

SPI 20 List four modifications that can be made to clothes to facilitate self-dressing by individuals with severe motor handicaps.

SPI 21 Describe at least five modifications that can be made to utensils, cups, plates, etc. to facilitate self-feeding by individuals with severe deficits in this area.

SPI 22 Describe how you could fade out over time special environmental modifications to promote skill development.

SPI 23 Explain the "Try Another Way" approach for habilitation of the severely and profoundly impaired.

SPI 24 Explain the need for precision in teaching the severely and profoundly impaired supporting your explanation with relevant citations from the literature.

SPI 25 List and discuss the major components necessary in teaching tasks to the severely and profoundly impaired.

SPI 26 List and discuss the major components necessary in teaching tasks to the severely and profoundly impaired.

SPI 27 Identify behaviors for change that are most likely to be supported by the natural environment.

SPI 28 Describe three necessary components of a behavioral objective.

SPI 29 Write specific behavioral objectives in areas of self-help, leisure time activities, personal hygiene and grooming, domestic activities, mobility and independence for the severely impaired.

SPI 30 Identify the role of task analysis in teaching community living skills to the severely and profoundly impaired.

SPI 31 List an ordered sequence of steps leading to a behavioral objective for a variety of daily living skills (e.g., money handling, learning, food preparation, social interaction, etc.).

SPI 32 Outline an instructional sequence based on an errorless learning paradigm, specifying trainer and resident behaviors.

SPI 33 Outline an instructional sequence based on a basic discrimination training model, specifying trainer and resident behaviors.

SPI 34 Describe the relevance of existing self-help programs for individuals with severe and profound impairments for those individuals in community placements.

SPI 35 Identify the critical conditions in teaching self-help skills (e.g., hair care, tooth brushing, feminine hygiene) to the severely and profoundly impaired.

SPI 36 Identify prerequisite resident skills before initiation of a toilet training program.

SPI 37 Compare and contrast two model toilet training programs (e.g., Azrin and Foxx, 1971; Piper and Meddock, 1978).

SPI 38 Specify the reasons one might teach an individual auxiliary toileting behaviors (e.g., pulling down pants, sitting down) prior to toilet training.

SPI 39 List at least five behaviors prerequisite to self-feeding.

SPI 40 Outline a sequence of steps to produce an individual who self-feeds drawing from the research on feeding (e.g., mini-meals, etc.).

SPI 41 Cite two methods of fading verbal prompts during self-help training.

SPI 42 Identify four problems which may interfere with the maintenance of previously acquired self-help skills.

SPI 43 Identify two prerequisite behaviors for functional language development in the severely involved.

SPI 44 Describe current language training programs for the severely involved detailing their assumptions and teaching strategies.

SPI 45 Identify conditions under which an imitation training procedure should be used to promote skill acquisition.

SPI 46 List the behaviors which should be in the repertoire of an individual prior to teaching the imitation of motor movements.

SPI 47 Outline the steps one should follow in an imitation training procedure.

## References for the Severely and Profoundly Impaired Track Competencies

Azrin, A. H. and Foxx, R. M. *Toilet training the retarded: A rapid program for day and night-time independent toileting*. Champaign, Illinois: Research Press, 1973.

Piper, T., and Meddock, T. D. "Toileting." In S. E. Gerweck (Ed.). *Compet II: Commonwealth plan for education and training mentally retarded children*. Harrisburg, Pennsylvania: Pennsylvania Department of Education, 1978.

## 14. Vocational Appraisal (VA)

### a. Goal

To demonstrate proficiency in appraising and teaching residents those prevocational concept and skills essential to obtaining and maintaining employment.

### b. Competencies

The RA Trainee should be able to:

VA 1 Teach the resident independent performance in crossing the street so that he:

(1) identifies and independently performs motor responses to the following signs: WALK, DON'T WALK, STOP, GO, ENTRANCE, EXIT, POLICE, TELEPHONE
(2) walks on the sidewalk facing traffic or makes correct judgments about a safe route
(3) stops at intersections
(4) stops at crosswalks
(5) looks both ways before crossing
(6) constantly looks for oncoming cars

VA 2 Describe at least six strategies for increasing the steadiness and consistency of work pace (i.e., to heighten those areas that diminish distractability and increase quantity of work).

VA 3 Cite four strategies for teaching a client acceptance of supervision (i.e., reaction to feedback, and pressure).

VA 4 Cite three strategies for teaching proper dressing combinations (i.e., color combinations, cloth combinations, etc.) so as not to attract negative attention. Implement one of these with a resident.

VA 5 Describe how to teach residents the coping skills they need to develop to eliminate the interference of personal problems with work.

VA 6 Describe how days of the week can be taught and do so with a resident.

VA 7 Explain the importance of seeing a task through to completion.

VA 8 Explain the importance of work organization (i.e., systematic approach to tasks) and describe how one can develop a generalizable strategy for systematically approaching work.

VA 9 Describe a strategy for teaching each of the following and implement one of these strategies with a resident:

(1) cashing a check
(2) making change for a vending machine
(3) writing one's name
(4) printing one's name
(5) printing one's address
(6) printing one's phone number

VA 10 Specify guidelines for developing an individual daily schedule of eating and sleeping.

VA 11 Design an individual program for a specific resident which involves teaching him to refrain from physical or verbal abuse, when angered.

VA 12 Specify how a resident could be taught to follow a six sequence series of instructions, given a set of data.

VA 13 Describe a strategy for teaching a resident to use a pay phone, and implement the strategy with a particular resident.

VA 14 Identify the steps in teaching a resident to use each of the following and teach a particular resident to use the mode of transportation which is most appropriate for him.

(1) bus
(2) taxi cab
(3) subway
(4) jitney

VA 15 Task analyze the following self-help skills:

(1) toothbrushing
(2) hairwashing
(3) using deodorant
(4) shaving
(5) putting on shoes
(6) putting on socks
(7) putting on pantyhose
(8) cleaning dentures
(9) inserting dentures
(10) blowing one's nose

## References

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5

## Chapter 5

# ALA MODEL CURRICULUM AND SAMPLE PROGRAM IMPLEMENTATION

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## INTRODUCTION

Staffing alternative living arrangement (ALA) settings with competent direct service personnel (e.g., resident advisors, senior resident advisors, houseparents, etc.) will surely be one of the most critical initiatives to be undertaken in the establishment of a comprehensive continuum of community-based residential services for developmentally disabled citizens. Central to the community-based services mandate are two basic notions: (a) that alternative living arrangement services should serve all developmentally disabled populations including the more severely mentally, physically and behaviorally handicapped and (b) that alternative living arrangement services should be more than just custodial efforts; i.e., they should contribute significantly to client growth enabling the resident to achieve increasing levels of independence and adjustment to community living.

Given the above, it becomes imperative that the level of expertise required on direct service ALA manpower levels be substantially increased. Surely the preceeding chapters on resident advisor competencies and the role and functions of the Resident Advisor have provided ample support for a movement toward professional training of ALA direct service personnel. The model curriculum which follows is intended to provide the basis for development of such training programs. Thus, the purpose of this chapter is to provide ALA curriculum designers with a comprehensive delineation of relevant curricular units as well as a sample program model to facilitate the development of ALA training programs responsive to the unique programatic requirements of particular academic institutions.

## STRUCTURE AND APPLICATION OF THE MODEL CURRICULUM

Although the model curriculum which follows was based upon extensive input from expert consultants, members of the state-wide advisory committee, the expertise of the project staff and upon the review of volumes of ALA related training curricula and material, it is not in and of itself necessarily complete nor appropriate for every ALA program application. Just as a list of competencies must be adapted to formulate a series of instructional objectives suitable for specific program needs, so too a model curriculum must be adapted to realistically and effectively address an individual college's program needs and implementation requirements. Thus, one academic institution contemplating an ALA training program may choose to offer a one-semester certificate program which draws upon salient selected core aspects of the model curriculum while another academic institution may elect to draw upon a majority of the model curriculum, including the specialization areas, to develop a four-year, service-specific track in ALA services.

Many factors will influence a college's ALA program development plans. These factors will arise both internally and externally. Internal factors will include such variables as program resources (e.g., faculty, space, administrative support, etc.), organizational characteristics and prior experience and program offerings in ALA program development. External factors will include such variables as the demand for various levels of ALA manpower in a particular geographic area of the state (e.g., number of current and planned ALAs, proximity of other training programs, etc.), availability of practicum sites and program funding supports.

With the above perspectives in mind, the model curriculum will now be presented in four parts. The first section will detail a series of core training experiences; part two will contain specialty areas (i.e., working with medically complex, profoundly impaired, multiply handicapped and/or behaviorally maladaptive); part three outlines guidelines for supervised practicum experiences; and part four includes a sample ALA training program.

## PART 1: ALA MODEL CURRICULUM CORE CURRICULAR UNITS

### I. Human Growth and Development

A. Normal Development (Life Span Overview)
1. Developmental Theory (Piaget, Freud, Bandura, etc.)
2. Physical Development
3. Emotional Development
4. Social Development
5. Cognitive Functions
    a) Speech and language development
    b) Cognition and intelligence
6. Drives, Motivation & Environmental Factors Influencing Development

B. Atypical Patterns of Growth and Development
1. Genetic
2. Neurological
3. Glandular
4. Social-Cultural
5. Emotional
6. Behavioral

### II. Introduction to Developmental Disabilities

A. Definitions, Causes and Incidence of Developmental Disabilities
1. Mental Retardation
2. Cerebral Palsy
3. Epilepsy
4. Learning Disabilities
5. Autism
6. Other Disabilities as defined by PL 95-602

B. Terminology and Classification
1. Educational Perspective
2. Psychological Perspective
3. Medical Perspective
4. Vocational Perspective

C. Behavioral Characteristics and Life Span Potential of Developmentally Disabled Persons
1. Educational
    a) Mildly involved
    b) Moderately involved
    c) Severely involved
    d) Profoundly involved
2. Vocational
    a) Mildly involved
    b) Moderately involved
    c) Severely involved
    d) Profoundly involved

- D. Prevention of Developmental Disabilities
  - 1. Public Awareness and Education
  - 2. Prenatal Care
    - a) Medical care (full-term)
    - b) Adequate diet, exercise and mental preparation
    - c) Avoidance of risk factors
      - 1) x-rays and radiation
      - 2) unprescribed drugs
      - 3) toxicants
      - 4) rubella
      - 5) syphilis
      - 6) trauma
      - 7) others
    - d) Genetic counseling and testing
  - 3. Perinatal Readiness
    - a) Planning for anticipated difficulties
    - b) Competent medical support and delivery
  - 4. Postnatal Testing and Follow-up
    - a) Vaccination program
    - b) Pediatric aftercare

## III. Orientation to Therapeutic Approaches and Community-Based Support Services

- A. Early Intervention Programs
  - 1. Identification and Awareness
  - 2. Follow along (Periodic Screening, Diagnosis and Treatment)
  - 3. Infant Stimulation (up to age 2)
  - 4. Toddler Developmental Programs (age 2-3)

- B. Educational Programs
  - 1. Preschool Developmental Programs (age 3-6)
  - 2. Public School Classes (age 6-21)
    - a) Regular classes
    - b) Resource room and regular class
    - c) Special classes
      - 1) TMR classes
      - 2) EMR classes
      - 3) ED classes
      - 4) LD classes
      - 5) Sensory impaired classes

- C. Day Activity Programs for Adults
  - 1. Young Adults (aged 21-35)
  - 2. Adults (aged 35-55)
  - 3. Older Adults (over 55)

- D. Vocational and Rehabilitation Services
  - 1. Prevocational
  - 2. Sheltered Workshop
  - 3. Sheltered Community Employment
    - a) Group work stations
    - b) Individual work stations
  - 4. Competitive Community Employment
  - 5. Independent Living Preparation

E. Social Services
  1. Case Management (individual)
  2. Information and Referral
  3. Coordination of Services

F. Recreation, Socialization and Leisure Programs
  1. Health and Exercise
  2. Sports (individual/group)
  3. Hobbies and Interests
  4. Arts and Crafts
  5. Social Development
  6. Motor Development
  7. Self Image Development
  8. Adaptive Recreational Activity

G. Family Services
  1. Genetic Counseling
  2. Marriage and Family Planning (client)
  3. Family Counseling and Training (parents, siblings)
  4. Family Counseling and Training (client)
  5. Homemaker Services
  6. Respite Care
  7. Nursing and Attendent Care

H. Residential Services (least restrictive, see Section XI)
  1. Community-Based Alternative Living Arrangements
    a) ALA Settings for Children
    b) ALA Settings for Adults
  2. Institutional Residential Support
    a) Development Maximization Units
    b) Short-term Habilitative Care
    c) Long-term Residental Care

I. Generic Health Care
  1. Family Medicine
  2. Pharmacology
  3. Medical specialists
  4. Partial hospitalization
  5. Hospitalization (short term)

J. Adjunctive Therapies
  1. Occupational
  2. Physical
  3. Movement
  4. Art
  5. Music
  6. Play
  7. Family

K. Evaluation, Consultation and Counseling Services
   1. General Medical
   2. Specialized Medical
      a) Cardiology
      b) Dental and Oral Surgery
      c) Neurology
      d) Obstetrics and Gynecology
      e) Ophthalmology
      f) Orthopaedic
      g) Psychiatric
      h) Urological
   3. Speech and Hearing
   4. Psychological
   5. Adaptive Behavior and Activities of Daily Living
   6. Vocational
   7. Educational
   8. Adjunctive Therapies
   9. Family Services

L. Transportation Services
   1. Private Vehicles
   2. Specialized Transportation and Modified Motor Vehicles
      a) client operated
      b) non-client operated
   3. Public Transportation
   4. Mobility Training (access and use)
      a) Public Modes
      b) Private
         1) Driver training (stock or modified)
      c) Non-motorized Modes
         1) Walking
         2) Bike

M. Specialized Technical Services, Apparatus and Supplies
   1. Physically Disabled
   2. Sensory Disabled
   3. Medical Needs

N. Self-Help and Voluntary Consumer Organizations
   1. Information and Referral
   2. Counseling and Peer Support
   3. Direct Services
      a) Education and training
      b) Vocational
      c) Evaluation and testing
      d) Other
   4. Advocacy Services
      a) Individual
      b) Group/class

O. Protective and Advocacy Services
   1. Citizen Advocacy
      a) Friend advocate
      b) Guide advocate

  2. Guardianship
  3. Foster Parenthood
  4. Adoptive Parenthood
  5. Class Action and Group Advocacy

P. Case Management Agencies (public)
  1. Mental Health, Mental Retardation Centers/Base Service Units

## IV. Special Concerns of the Developmentally Disabled Adolescent and Adult

A. Sexuality and Intimacy
  1. "Nonsexual view" of the Developmentally Disabled
  2. Anatomy and reproduction
  3. Societal sexual values
  4. Your sexual values
  5. Developing intimacy
    a) The art of loving and caring
    b) Friendship
    c) Dating
  6. Human sexual expression (Social/Legal)
    a) Acceptable range
    b) Controversial range
    c) unacceptable range
  7. Birth Control
  8. VD
  9. Sex Education
  10. Sterilization: past and present

B. Social Roles
  1. Social Sterotypes and Myths
  2. Parents Expectations and Reactions
  3. Social Growth and Personal Development
    a) Developing responsibility and autonomy
    b) Parenthood (clients)
    c) Self-fulfillment
    d) Self-Determination
    e) Peer Support (disabled/nondisabled)
    f) Positive self-image
    g) Assertiveness
    h) Interpersonal skills
    i) Sensitivity to physical and psychological needs (self/others)
  4. Normalized Lifestyle
  5. Social equality
  6. Occupation
    a) Significance of occupation
    b) Psycho-social perspective (work ethic)
    c) Vocational alternatives for severly disabled
  7. Family Relations (parents, siblings, relatives and significant others)
    a) Dependence
    b) Mutual support
    c) Life after parents pass away

## V. Human Service Philosophies: Past, Present and Future

- A. Historical Views of Deviancy and the "Treatment" of Deviants
    - 1. Ancient Times
        - a) Extermination and abandonment
    - 2. Precolonization
        - a) Ridicule
        - b) Superstition
            - 1) Worshipped
            - 2) Persecuted as evil
    - 3. Colonization
        - a) Protection
            - 1) For society (eugenics)
            - 2) From society (object of pity)
        - b) Custodial Care
        - c) Treatment Period
        - d) Education and Training
    - 4. Deinstitutionalization
        - a) Discovery of Psychopharmacological Agents
        - b) Innovative Programs
        - c) National Awareness (PCMR)
        - d) Research and Prevention
        - e) Normalization
            - 1) Human Rights
            - 2) Community-based Services
        - f) Period of Advocacy
            - 1) Citizen Advocacy
            - 2) Legislation
            - 3) Litigation
        - g) Period of Accountability (Institutional and Community-Based)
            - 1) Program evaluation
            - 2) Client outcome measures
            - 3) Cost/benefit evaluation

- B. Local History of Residential Services
    - 1. Development of State Acts
    - 2. Development of Public Services
    - 3. Development of Voluntary Organizations

- C. The Principle of Normalization
    - 1. Definition (Nirje, Wolfensberger)
    - 2. Implications for Residential Services
        - a) Normal daily routines
        - b) Normal patterns of life
        - c) Culturally normative perspective
        - d) Personal dignity and autonomy
        - e) Human and civil rights insured
        - f) Specialization
        - g) Social integration
        - h) Utilizing generic community services
        - i) Age appropriateness
        - j) Small, home-like residential settings

3. Program Analysis of Service Systems (PASS)
   a) Educational Perspective (vis-a-vis normalization)
   b) Evaluation Perspective
      1) Advantages
      2) Limitations

D. Perspectives on Human Service Problems
   1. Systemic view (global)
   2. Clinical view (individual)
   3. Ecological view (interactive)

E. National and International Trends Shaping the Future of Residential Services Ideology
   1. Social Trends
   2. Economic Trends
   3. Political Trends
   4. Resource Allocation
   5. Cultural Norms Redefined
   6. Effects of Accountability Period
      a) Institutional
      b) Community-Based

## VI. Program Design, Implementation and Evaluation in Alternative Living Arrangements

A. Techniques for Individual Program Planning and Evaluation
   1. Individualized Program Plans
      a) Definition and Purpose
      b) Needs Assessment and Preskills
      c) Setting priorities and goal planning
         1) Strength vs. problem approach
         2) Including the client in goal planning
         3) Short-term goals
         4) Intermediate goals
         5) Long-term goals
      d) The whole person perspective
      e) Interdisciplinary approach
      f) Writing skills for IPP's
      g) Task Analysis
      h) Task Simplification
      i) Precision Teaching
   2. Observing Behavior
      a) Defining behavior
      b) Observational methods
   3. Recording Behavior
      a) Types of Data
         1) frequency
         2) duration
         3) interval
         4) intensity
      b) Charting and data collection methods
      c) Baselines
      d) Progress notes
   4. Monitoring, Evaluation and Redesign of IPP's

- B. Assessment Instruments and Program Evaluation
  - 1. Commonly Used Standardized Assessment Instruments
    - a) Intelligence (WAIS, WISC-R, SB, Bayley, etc.)
    - b) Reading, Perceptual-Motor Skills (Bender, MVPT, ITPA, GFTA, etc.)
    - c) Math (WRAT, Key Math, etc.)
    - d) Adaptive Behavior and Independent Living (ABS, VSMS, PAC, etc.)
  - 2. Critical Analysis of Psychological Reports and Case Histories
  - 3. ALA Program Evaluation
    - a) Types of Evaluation
      - 1) Process
      - 2) Outcome
      - 3) Cost/benefit
    - b) Evaluation Methodology
      - 1) Self-Evaluation and goal attainment scaling
      - 2) External Evaluation
        - aa) PASS
        - bb) FUNDIT
        - cc) ANDI
        - dd) CCEM

- C. Program Content for ALA Services
  - 1. Activities of Daily Living and Adaptive Behavior Skills (client)
    - a) Personal Maintenance
      - 1) Personal hygiene
        - aa) Health and exercise
        - bb) Use of talc, deodorants, etc.
          - bathing
          - shaving
          - foot care
          - hair care and grooming
      - 2) Taking medications (if appropriate)
      - 3) Oral hygiene
      - 4) Menstrual hygiene
      - 5) Care of personal belongings and room
      - 6) Maintenance of room (making bed, straightening up, etc.)
    - b) Group Maintenance
      - 1) Laundry and Ironing
      - 2) Dry Cleaning
      - 3) Meal Planning
        - aa) menu development
        - bb) nutrition (balanced menu)
        - cc) shopping list (for menu plan)
      - 4) Meal Preparation
        - aa) cooking terminology
        - bb) cooking methods
        - cc) reading recipes
        - dd) measurement
        - ee) following product directions
        - ff) using kitchen appliances (major/minor)
        - gg) using kitchen utensils
        - hh) safety in the kitchen

    - 5) Food Storage
    - 6) Housekeeping
        - aa) Cleaning (sweeping, dusting, etc)
        - bb) Straightening up rooms
        - cc) simple home repairs
        - dd) yard, lawn and/or patio maintenance
- 2. Socialization Skills
    - a) Etiquette and manners
    - b) Communication Skills
        - 1) Verbal
        - 2) Nonverbal
        - 3) Assertiveness training
        - 4) Human relations training
    - c) Social responsibilities
        - 1) work habits
            - aa) appropriate dress
            - bb) punctuality
            - cc) duties
        - 2) House Responsibilities (ALA)
            - aa) house rules
            - bb) duties and housekeeping tasks
    - d) Socially accepted behavior (local norms)
        - 1) public settings (bus, stores, street, etc.)
        - 2) private settings (home, parties, etc.)
            - aa) among friends
            - bb) among strangers
    - e) Sexuality and Peer Relationships
        - 1) sex education
        - 2) birth control
        - 3) VD
            - aa) definition
            - bb) prevention
            - cc) treatment
        - 4) Sexual expression
            - aa) masturbation
            - bb) dating
            - cc) sexual relationships (hetero/homosexual)
- 3. Money Management
    - a) coin recognition
    - b) currency value and making change
    - c) budgeting
        - 1) making and using a budget
        - 2) personal expenses
        - 3) group or shared expenses
        - 4) personal assets (client)
            - aa) food stamps
            - bb) paychecks
            - cc) SSI payments
            - dd) other resources
    - d) Banking
        - 1) saving accounts
        - 2) checking accounts
        - 3) other bank services

4. Consumer Education
    - a) Making purchases
        - 1) comparative shopping
        - 2) sales and use of coupons
        - 3) guarantees and warranties
        - 4) product labels
        - 5) product safety
    - b) Contracts
        - 1) estimates
        - 2) proposals
        - 3) entering contracts
    - c) Consumer Rights

5. Utilizing Community Resources (locating and accessing)
    - a) Shopping Centers, Malls, etc.
        - 1) home needs
            - aa) food
            - bb) supplies
            - cc) furniture and appliances (minor)
            - dd) housewares
        - 2) personal needs
            - aa) goods (clothes, personal belongings, etc.)
            - bb) services (hair stylist, shoemaker, dry cleaner, etc)
    - b) Program Services (see Section III)
    - c) Support Services (see Section III)
    - d) Medical Services (see Section III)
    - e) Public Services
        - 1) Post Office
        - 2) Police Department
        - 3) Fire Department
        - 4) Information Services
    - f) Recreational and Leisure Time Resources
        - 1) Public facilities
            - aa) parks
            - bb) playgrounds
            - cc) pools
            - dd) gyms
            - ee) tennis courts
            - ff) baseball and football fields
            - gg) skating rinks
            - hh) library
            - ii) golf courses (including miniature)
            - jj) other
        - 2) Private facilities (as above but not open to nonmembers)
        - 3) Recreational Programs (public, private or specialized agency)
            - aa) indoor sports (individual/team)
            - bb) outdoor sports (individual/team)
            - cc) fitness and health
            - dd) adult education classes
            - ee) hobby and interest development
            - ff) dance

- gg) yoga, meditation and relaxation techniques
- hh) art (painting, sculpture, etc.)
- ii) crafts (woodworking, ceramics, etc.)
- jj) other

- 4) Socialization Programs (see Section 111-F)
    - aa) Specialized Sponsor (UCPA, ARC, etc.)
    - bb) Nonspecialized sponsor (local youth groups, etc.)
    - cc) Home-Based (staff/client sponsored picnics, parties, recreational activities)

- g) Use of Telephone
- h) Public Transportation
    - aa) bus
    - bb) subway
    - cc) train
    - dd) cab
- i) Mobility Training (Public Transportation)
    - aa) location
    - bb) access
    - cc) purchasing tickets and tokens
    - dd) paying fares
    - ee) transit maps
    - ff) transfers

## VII. Teaching New Behavior and Behavior Management

A. Teaching and Maintaining Behavior
- 1. Readiness and Preskills
- 2. Cues
- 3. Prompting
- 4. Fading
- 5. Shaping
- 6. Chaining
    - a) Forward
    - b) Backward
- 7. Generalization and Maintenance

B. Creating Facilitating Learning Environments
- 1. Minimizing distractions
- 2. Insuring a measure of success
- 3. Creating motivation and interest
- 4. Preparation
- 5. Physical comfort
- 6. Emotional comfort
- 7. Two-way Participation and Ownership
- 8. Developmental sequencing

C. Review of Learning Theory
- 1. Respondent Conditioning
- 2. Operant Conditioning

D. Behavior Modification Principles and Techniques
- 1. Targeting Behavior for Change
    - a) Defining Inappropriate Behavior
        - 1) Poses Danger to Self

      2) Poses Danger to Property
      3) Non-normalizing (maladaptive)
      4) Poses Danger to Safety or Rights of Others
  2. Definition of Target Behavior
  3. Identification of Antecedents
  4. Identification of Maintaining Consequences
    a) Stimulus Control
    b) Stimulus Discrimination
  5. Selecting Methodology
    a) Strengthening Behavior
      1) Definition of reinforcers
      2) Immediacy and consistency of reinforcers
      3) Strength of reinforcers
      4) Schedules of reinforcement
      5) Contingency Contracting
      6) Token Systems
    b) Weakening Behavior
      1) Extinction
      2) Differential Reinforcement of Other Incompatible Behavior (DRO)
      3) Systemic Desensitization
      4) Satiation
      5) Response Costs and Punishment
  6. Implementation
  7. Evaluation
    a) Reliability
    b) Effectives (criteria)
  8. Modification and Redesign
  9. Maintenance of Behavior

E. Issues Concerning Punishment
    a) Always explore more positive alternatives
    b) Disadvantages and undesirable side effects

F. Ethical and Legal Perspectives on Behavior Management
  1. Rights (cannot be taken away)
  2. Behavior Change Programs should be Humanistic and promote Normalization
    a) Defining Inappropriate behavior
    b) Age Appropriate programs
    c) Risk vs. Benefits
  3. Human Rights Committees and Program Review Boards
    a) Purpose
    b) Function

VIII. Human Interaction, Problem Solving and Counseling Techniques in ALA Settings

A. Group Process Theory and Issues
  1. Membership
  2. Facilitating Interaction
  3. Intimacy Development
  4. Power and Influence

5. Interpersonal Communication and Feedback
6. Group Norms
7. Leadership
8. Group Functions
   a) Task
   b) Maintenance
   c) Process
9. Stages of Group Development

B. Problem Solving Techniques
   1. Crisis Theory
   2. Crisis Intervention
   3. Conflict Resolution
   4. Setting Limits (house rules)
      a) Rationale
      b) Involving residents in rule making
   5. Problem Solving and Decision Making
      a) brainstorming
      b) categorizing
      c) prioritizing
      d) strategizing
      e) role playing

C. Values Clarification
   1. Formation of values
   2. Societal Impact
   3. Changing Values

D. Interviewing Techniques

E. Interacting with the Developmentally Disabled Resident's Family
   1. Family Dynamics
   2. Parental Reactions to Disability in Family
   3. Effects on Family Life
      a) Immediate and Long-Range
         1) Economic
         2) Psychological
         3) Social
   4. Developing Rapport

F. Counseling Techniques

G. Developing Peer Support Networks
   1. Resident to Resident
   2. Resident to Staff
   3. Staff to Staff
   4. Resident/Staff to Community

H. Self-Renewal and Personal Growth (staff and client)
   1. Identifying needs and wants
      a) in self
      b) in others
   2. Communicating needs and wants
   3. Self-Actualization and Renewal
   4. Assertiveness Training

- I. Community Relations
  - a) reducing or eliminating common fears and misconceptions about ALA settings in the community viz:
    - 1) fear of communal life style
    - 2) attraction and attention
    - 3) devaluation of property
    - 4) fear of physical harm
    - 5) fear of sexual deviance
    - 6) racial predudice
    - 7) inadequate supervision
    - 8) fire hazard
    - 9) contagious disease and infections
  - b) zoning and licensing

## IX. ALA Program Maintenance--I

- A. Emergency Management, Medications and Toxic Substances
  - 1. Emergency Plans
    - a) Emergency Phone Numbers
    - b) Fire Drills
    - c) Medical Emergencies
    - d) Behavioral (violent episodes)
  - 2. Emergency Procedures
    - a) Medical (First Aid)
      - 1) wounds/control of bleeding
      - 2) shock
      - 3) artificial respiration and CPR
      - 4) poisoning and antidotes
      - 5) fractures and broken bones
      - 6) heart attack
      - 7) seizures (major)
      - 8) burns
      - 9) heat exhaustion and overexposure to sun
      - 10) frostbite
      - 11) head injury
      - 12) bites (insects, animal, human)
      - 13) eye injuries
      - 14) blockage of air and food passages
      - 15) diabetic coma
      - 16) Insulin Shock (hypoglycemia)
      - 17) Drug overdose
    - b) Fire
      - 1) types of fires
      - 2) types and use of fire extinguishers
      - 3) care of fire extinguishers
      - 4) fire hazards
      - 5) fire prevention
      - 6) conducting fire drills
    - c) How to Handle Violent Behavior Episodes
      - 1) Self-Imposed
        - aa) self-abuse
        - bb) suicide attempts
      - 2) Violence Toward Others
        - aa) armed
        - bb) unarmed

        - 3) Violence Toward Property
        - 4) Emergency Restrictive Procedures
- 3. Safety in the Home
    - a) Preventing Accidents in the:
        - 1) kitchen
        - 2) bathroom
        - 3) workroom
    - b) Storage and Handling of Toxic and Flammable substances
    - c) Electrical Safety

B. Discovery and Utilization of Generic Community Resources

- 1. Inventory of local resources (public and private)
    - a) Medical
        - 1) General Practice
        - 2) Specialists
        - 3) Dentist
    - b) Daytime Programming
        - 1) Educational (See Section III-B)
        - 2) Vocational (See Section III-D)
        - 3) Day Activity Programs (See Section III-C)
    - c) Supportive Services (See Section III)
    - d) Mental Health/Mental Retardation BSU
    - e) Voluntary Organizations (e.g., UCPA, ARC, etc.)
    - f) Emergency Facilities
        - 1) Hospitals
        - 2) Fire House
        - 3) Police Station
    - g) Civic Organizations
    - h) Self-Help Consumer Organizations (e.g., Disabled in Action)
    - i) Professional Organizations
    - j) Local Legislators
    - k) Public Services/Offices
    - l) Church, Synagogue, etc.
    - m) Retail Shopping Centers, Malls, etc.
    - n) Supermarkets, food stores
    - o) Recreational and Leisure Facilities (See Section VI-5f)
    - p) Night Life (disco, bars, etc)
    - q) Public Transportation Routes
    - r) Others
- 2. Strategies for Integrating Residents into the Community
    - a) Forming Social Networks
    - b) Joining Neighborhood Groups
    - c) Community Education
        - 1) Formal Methods
            - aa) presentations
            - bb) media
        - 2) Informal Methods
            - aa) over tea
            - bb) open house
            - cc) natural interaction
    - d) Using Generic Resources As Much As Possible

- C. Basic Pharmacology
  - 1. Types and Uses (Desired Responses) of Selected Medications
    - a) antacids
    - b) antibiotics
    - c) antihistamines
    - d) aspirin
    - e) blood pressure drugs
    - f) diabetic drugs
    - g) epilepsy drugs
    - h) heart drugs
    - i) laxatives
    - j) antidepressants
    - k) sleeping pills and sedatives
    - l) tranquilizers
    - m) hormones
    - n) sulfonamides
    - o) others relevant to individual needs
  - 2. Guidelines for:
    - a) Administration
    - b) Storage
    - c) Record Keeping
  - 3. Dangerous Drug Interactions
  - 4. Activities of Daily Living Affected by Various Drugs
    - a) attention
    - b) mood
    - c) diet
    - d) elimination
    - e) physical activity
  - 5. Drug and Alcohol Abuse

## X. ALA Program Maintenance - II

- A. Nutrition and Meal Planning
  - 1. Average Nutritional Needs
    - a) Children
    - b) Adults
  - 2. Factors Influencing Nutritional Needs
  - 3. Planning Menus
    - a) Food Groups and balanced diet
    - b) Variety
    - c) Economy
    - d) Special diets
      - 1) Types
        - aa) weight gain
        - bb) weight loss
        - cc) low sodium
        - dd) other
      - 2) Medical Supervision
  - 4. Meal Preparation
    - a) using kitchen utensils
    - b) basic cooking skills
  - 5. Food Storage
    - a) refrigeration
    - b) frozen storage

- c) recognizing spoiled food
- d) handling foods
- e) preventing food poisoning

6. Comparative Food Shopping
7. Food Sources of:
    - a) Vitamins (A, B, C, D, E, K)
    - b) Minerals
    - c) carbohydrates
    - d) fats
    - e) proteins

B. Health and Hygiene

1. Aspects of Good Health
    - a) Physical
    - b) Mental/Emotional
    - c) Social (Life Style)
    - d) Spiritual
2. Basic Anatomy and Physiology
    - a) Major body systems
        - 1) Identification and Location
        - 2) Function
3. Health Problems, Identification and Treatment
    - a) General respiratory
        - 1) colds
        - 2) flu
        - 3) Asthma
        - 4) Bronchitis
    - b) Elimination
        - 1) constipation
        - 2) diarrhea
    - c) Skin
        - 1) blackheads
        - 2) pimples
        - 3) others
    - d) Hair
        - 1) Dandruff
        - 2) Excess oil/dryness
    - e) Feet
        - 1) Arch trouble
        - 2) Corns and Bunions
        - 3) Calluses
    - f) Weight
        - 1) over
        - 2) under
    - g) Mental health problems
        - 1) Psychoneuroses
        - 2) Character Disorders
        - 3) Psychoses
        - 4) Other
    - h) Disease producing organisms
    - i) When to call a doctor
4. Health Maintenance
    - a) Diet (See Section X-A)
    - b) Personal Hygiene (See Section VI-C-1a)

- c) Posture and exercise
- d) Recreation and relaxation
- e) Medical care and check-ups
- f) Pleasant home environment
  - 1) Physical
  - 2) Affective

5. Prosthetics
   - a) Use
   - b) Care

C. Report Writing and Record Keeping
1. Incident Reports
   - a) Accident
   - b) Behavioral Episode
   - c) Death
2. Fiscal Records
   - a) house budget data
   - b) client accounts
3. Data Organization
   - a) client records
   - b) files (nonclient)
   - c) receipts
4. Program Plan Logs
   - a) client summary
   - b) goals
   - c) current programs
   - d) evaluation
   - e) progress notes
5. Confidentiality

D. New Resident Procedures
1. Transitional Planning
2. Intake Procedures
3. Orientation

E. Existing Resident Procedures
1. Involvement in program development
2. Enlist feedback

F. Home Maintenance and Design
1. Housekeeping
2. Scheduling (self and client)
   - a) Appointments
   - b) Home Maintenance tasks
   - c) Program Activities
     - 1) inside ALA (home program)
     - 2) outside ALA (education, recreation, etc)
3. Simple Home Repairs
   - a) Use of tools
     - 1) hand
     - 2) power
4. Orientation to Household Systems
   - a) Gas
   - b) Electric

        c) Heat
        d) Water
        e) Air Conditioning
    5. Interior Design
        a) Principles of decoration
        b) Creating adaptive/facilitative living space

G. Insurance (For Resident Advisor, Clients and Program)
    1. Property
    2. Liability
    3. Vehicle
    4. Health
    5. Malpractice (Resident Advisor)

## XI. The Residential Services Delivery System Structure, Models of Service and Issues

A. An Overview of Local, Regional, State and National Human Service Systems Impacting ALA Services
    1. Enabling Legislation
    2. Regulations
    3. Funding Streams
    4. Organization
    5. Services
    6. Program Accountability and Evaluation

B. Toward A Comprehensive Continuum of Community-Based Support Models
    1. ALA Settings for Children (0-18 years)
        a) In-home family care (support to family)
        b) Foster homes (individual placement)
        c) Developmental homes (group placement)
        d) Behavior shaping units (short-term group placement)
        e) Respite care (very-short-term group placement)
    2. ALA Settings for Adults (18 +)
        a) Independent Residences (homes, apartments, etc)
            1) individual placement
            2) group placement
            3) married couple
        b) Semi-Independent Residences
            1) individual placement
            2) group placement
            3) married couple
        c) Boarding Homes
            1) individual placement
            2) group placement
        d) Transitional Residences (group placement)
            1) cluster apartments
            2) group homes
        e) Behavior Shaping Units (short-term group placement)
        f) Nursing Care (Older adults)
            [illegible] individual (board and care)
            2) small group (board and care)
            3) nursing home

3. Program rationale, facilitating characteristics and limitations of ALA settings
4. Optimal vs. Actual Continuum of Residential Services
5. Optimal vs. Actual Continuum of Support Services

C. Current Manpower Situation in ALA Services
    1. Organizational Patterns Among Provider Agencies
    2. Staffing Arrangements
    3. Job Descriptions
    4. Common Personnel Policies and Procedures
    5. Range of Pay Scales and Fringe Benefits (County/Statewide)
    6. Personnel Development and Insurance Training
    7. Current Manpower Problems
        a) Burnout
        b) Low salary
        c) Lack of Support
            1) Program services
            2) Psychological/Emotional
            3) Administrative
        d) Turnover
        e) Lack of Highly Trained Personnel
        f) Lack of Adequate Training Opportunities
            1) Preservice
            2) Inservice
        g) Causes and Maintenance of Manpower Problems
        h) What's being done to better ALA Manpower Situation

D. New Manpower Trends and Professionalization of Resident Advisorship (ALA Direct Service Personnel)
    1. Changing Characteristics of Resident Advisors and Emerging New Roles
        a) Old patterns
            1) inservice preparation
            2) secondary role in program plan design
            3) no credential or non-ALA specific credential
            4) unorganized labor
            5) unprofessional status
            6) inadequate wage
            7) accidentally in ALA services
            8) "job" is temporary, transitional orientation
            9) limited career mobility
        b) Emerging Patterns
            1) preservice preparation
            2) major role in program plan design
            3) ALA-specific credential
            4) professional organization or unionization
            5) professional/paraprofessional status
            6) fair wage
            7) aspire to ALA services
            8) career orientation
            9) attractive vertical and horizontal career mobility

E. Social Forces Impacting ALA Services
  1. Provider Organizations
  2. Parents and Voluntary Associations
  3. Self-Help and Advocacy Forces
  4. Standards
  5. Regulations
  6. Legislation
  7. Judicial Decisions
  8. Professionals
    a) Individual contributions in research and training
    b) Professional organizations

F. Issues in ALA Services
  1. Legal and Ethical Issues
    a) Legal and Ethical Responsibilities of the Resident Advisor
    b) Informed Consent
    c) Legal Competence
    d) Broadening of Client Rights
      1) Human Rights
      2) Civil Rights
      3) Right to Treatment
      4) Right to Education
      5) Right to Community Living
      6) Right to Access Community Services

## PART 2: ALA MODEL CURRICULUM SPECIALTY AREAS

### I. Medically Complex, Profoundly Impaired and Multiply Handicapped

A. Advanced Instructional Techniques
  1. Task Components
  2. Preskills for
    a) Concept learning
    b) Operational learning
    c) Problem-Solving Behavior
  3. Concept Analysis
  4. Program Theory
    a) Writing objectives from terminal skills
    b) Terminal behavioral objectives
    c) Component skills
    d) Interconnecting of programs
  5. Program Sequence Charting
  6. Advanced Program Analysis

B. Supplemental Program Content Areas for Severely Profoundly Impaired
  1. Menstrual Hygiene
  2. Toileting
  3. Self-Feeding
  4. Attending and Eye Contact
  5. Following Simple Directions
  6. Handwashing
  7. Bathing (bath, shower)
  8. Grooming Skills
    a) Hair Care
      1) washing
      2) brushing and combing
      3) styling and setting (age-appropriate and fashionable)
    b) Shaving
      1) Male (face)
      2) Female (legs and underarms)
    c) Mouth Care
      1) Brushing Teeth
      2) Using mouthwash
      3) Using Dental Floss
      4) Care of Dentures
    d) Body lotions, Powder and Deodorants
  9. Foot Care
    a) Cleaning toenails
    b) Clipping toenails
    c) Using foot powder
  10. Ear Care
  11. Face Care
    a) Washing
    b) Treating acne and skin problems
  12. Body Part Identification
  13. Posture
    a) Sitting
    b) Standing
    c) Walking

14. Dressing and Undressing
    a) Matching
        1) Colors
        2) Patterns
    b) Clothing Fasteners (front and rear operation)
        1) Snaps
        2) Buttons
        3) Zippers
        4) Hook and eye
        5) Belts
        6) Belt ties
    c) Overhead Garments
    d) Shoes
        1) Putting on
        2) lacing
        3) tying
    e) Context of Dress
        1) Weather
        2) Social Affairs
            a) Formal
            b) Informal
        3) Work
        4) Expression of Personality and Individuality

C. Physical Care
    1. Personal Hygiene
        a) Skin care
            1) Decubiti (care and prevention)
            2) Bathing Techniques
                aa) tub
                bb) bed bath
                cc) use of special equipment
        b) Hair
        c) Hands and Nails
        d) Mouth
        e) Dentures
    2. Positioning and Physical Maintenance
        a) Lifting
            1) floor to bed
            2) floor to chair
            3) turning over in bed
            4) supine to sitting position
            5) sitting to supine position
            6) into and out of a bathtub
            7) from wheelchair to toilet
            8) from wheelchair to chair
            9) from toilet to wheelchair
        b) Body Alignment
        c) Range of Motion (Active/Passive)
        d) Po[illegible]ing Restraints and Posture Equipment
        e) Protective Equipment
        f) Prosthetic Devices
            1) Purpose
            2) Use
            3) Care

- g) Toileting
  - 1) Training
  - 2) Care and use of bedpans
  - 3) Incontinence
  - 4) Perineal care
  - 5) Suppositories, Enemas and Cathartics
  - 6) Urine and stool specimens
- h) Exercise and Physical Therapy
  - 1) exercising joints
  - 2) maintaining muscle tone
  - 3) releasing spasms

3. Feeding Techniques
   - a) Swallowing disability
   - b) Food textures
   - c) Measuring food intake/output
   - d) Hygiene at feeding
   - e) Dignity at feeding
   - f) Posture at feeding
     - 1) Effects of gravity
   - g) Feeding interferences
   - h) Problems of rumination

D. Respiratory Care
1. Techniques of Drainage and Mucus Dispersal
2. Measuring Respiration and Temperature
   - a) Oral temperature
   - b) Auxillary temperature
   - c) Rectal temperature
   - d) Radial pulse
   - e) Carotid pulse
   - f) Sites of Measurement
   - g) Norms for body temperature
   - h) Blood pressure
3. Factors influencing respiration

E. Medical Aspects
1. Common Medical Problems
2. Recognizing and Reporting Illness and Distress Signs
3. Seizures
   - a) Types
     - 1) grand mal
     - 2) petit mal
     - 3) psychomotor
   - b) Recording and observation
   - c) Treatment
4. Medication
   - a) supplemental pharmacology
   - b) administration
     - 1) eye drops
     - 2) eye ointment
     - 3) topical medication
     - 4) doctor's orders (seven parts)
     - 5) pouring liquids
     - 6) divided nose
     - 7) handling powders, tablets and capsules

- c) Responsibilities when
  - 1) label becomes difficult to read
  - 2) label comes off
  - 3) medications are spilled
  - 4) becomes precipitous or changes color
  - 5) resident refuses medication
  - 6) resident advisor makes error in administration of medication

- F. Adaptive Equipment for Independent Living
  - 1. Eating
  - 2. Dressing
  - 3. Personal care
  - 4. Kitchen devices
  - 5. Modification of the Physical Environment
  - 6. Creating adaptive jigs

- G. Communicaton with Sensory/Speech Impaired
  - 1. Basic sign language
  - 2. Communication boards
    - a) Language boards
    - b) Symbol or picture boards
    - c) Use
    - d) Construction
  - 3. Basic Braille
  - 4. Special Problems of the Deaf/Blind Resident

## II. Serious Behavioral Needs

- A. Advanced Behavior Theory
  - 1. Review of Basic Behavior Theory
    - a) Operant behavior
    - b) Respondent behavior
  - 2. Advanced Behavioral Designs
    - a) Systematic Observational Techniques
    - b) Behavior Sampling and Recording Methods
      - 1) Time: Samples
      - 2) Latency samples
      - 3) Duration recording
      - 4) Interval recording
      - 5) Event vs. State Behavior
      - 6) Behavioral Coding Instruments
      - 7) Lindsey charts
    - c) Multiple Baselines
    - d) Reverse Designs
  - 3. Overview of Research in Applied Behavioral Analysis
    - a) Review of literature
    - b) Studies with Developmentally Disabled Subjects

- B. Stereotypic and Self-Stimulation Behavior
  - 1. Common manifestations
  - 2. Interventions (case history accounts)

C. Violent and Agressive Behavior and Methods for Reduction or Elimination
  1. Common manifestations
    a) aggression toward others
    b) self-abuse
  2. Interventions (case history accounts)
  3. Use of Restrictive/Aversive Interventions
    a) Cautions and conditions for use
    b) Procedures for use
    c) Types
      1) Contingent exclusion and time out from retirement
      2) Restitutional overcorrection
      3) Restraints
      4) P.R.N. Control of Behavior
      5) Punishment (Response costs)
      6) Negative reinforcement
      7) Aversion Therapy
  4. Systematic Desensitization
  5. Covert Conditioning
    a) Sensitization
    b) Modeling
    c) Reinforcement
  6. Self-Observation and Control
  7. Alternate Response Training
    a) Impulse control

D. Review of Ethical and Legal Issues in Behavior Management

# PART 3: GUIDELINES FOR SUPERVISED PRACTICUM EXPERIENCE

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Field placements are at once the most trying and the most beneficial aspect of an ALA training program. It is axiomatic in adult education that people learn by doing, provided that from the doing there is feedback. Establishing a sound field placement component is the best way of ensuring competent graduates (assuming that the classroom components are valid and effective).

There are a number of considerations to get sorted out before a training program administrator starts running around trying to find "good" field placements.

Intensive vs. Extensive. This is the question of whether it is better educationally to have students attend placements for a long period of time, thereby limiting the potential variety of placements any one student will see, but increasing the depth of exposure at each placement, or whether to have students attend a larger variety of placements, but for a shorter period of time each.

Extensive placements have some distinct advantages over intensive ones, in my opinion. Some of these are: a more marketable graduate, the ALA graduate will have a wider perspective on systems of service delivery, will have encountered a wider variety of clients, and will have at least been exposed to a wider variety of skills than if s/he were locked into a placement for a long training segment.

Graduates will probably be more marketable because of their diverse experience. In Ontario, most local associations for the mentally retarded (AMRs) look unfavorably upon applicants with only residential experience acquired in government (institutional) facilities. The reverse is not generally true, as the government facilities generally have a harder time attracting employees, notwithstanding their higher salaries. As the responsibility for service provision shifts ever more toward the private sector, I suspect that the hiring policies of the local AMR's will become more widespread, which selects for people from different backgrounds, with varied experience.

The graduate's perspective on systems of service delivery systems will be wider if s/he has done placement in 5 different agencies as opposed to 2. The more agencies (to a point) the student experiences, the more likely the student will be able to discriminate the impact of agency policy and structure upon clientele, and become aware of the locus of control of service providers. As well, students with more exposure to service systems are, I think, less likely to categorize one system or another as globally good or bad, but to employ more sophisticated analysis to their placement agencies. Of course, the obvious benefit to exposure is that the student (RA trainee) will be more likely to bring new ideas from one place to another ("cross-pollinate"), and to integrate new ideas and effective practices into their repertoires. Also true, unfortunately, is that if the student witnesses ineffective practices repeated at various placement agencies, such as do-nothing staff, overuse of chemical straightjackets, and the like, the student will also be more inclined to integrate these practices into his/her behaviour scheme. There is remarkably little a faculty member can do to counter the effect of "real-world" learning.

If the extensive placement philosophy is followed, it is clear that students can potentially become competent in a wider variety of skills than would be the case if they were limited to one or two agencies. Since agency clientele will vary from place to place, and staff will also vary, more behaviours displayed under more situations will be viewed by the student. If this does not result in overload for the student (there is a partial remedy for this - field seminars), s/he can garner a wide variety of modes of working with people. This extensive method also offsets the effect any one supervisor, "good" or "bad", can have on any one student.

Intensive placements, on the other hand, offer some advantages as well. In my opinion, however, they do not compensate for the loss of the advantages to be gained by the extensive approach.

One of the disadvantages of a student being exposed to a large variety of placements is that one is always, it seems, saying goodbye to a group of clients and staff (and fellow-students) and saying hello to a whole new patch of folks. This, in addition to the culture shock involved in learning an entirely new set of formal and informal rules of conduct, creates a very Toffleresque situation for students. Hooking a student to one placement agency for a fairly long stretch (e.g. a 3 or 4 month block placement) almost completely eliminates the shocks caused by rapid transition (or, perhaps it just reduces their number. Students do need to get used to change, but frequent placement switches may cause unsettling problems.

In addition to lessening culture shock, intensive placements provide a chance for the students to build relationships both with clients and staff. In terms of clients, what this means is that a student may have a chance to see the results of his or her programming or counselling efforts with a client, and the results of modifications in methodology made during the course of the placement. One of the difficulties in this field is obtaining enough satisfaction from slow changes by the client to provide sufficient reinforcement for the student (or fledgeling staff member) to maintain adequate motivation to continue to work in the field. This problem is reduced by intensive placement.

A related area is that, in human services fields generally, there is a need on the part of most workers (or would-be workers) for a support system surrounding oneself. This may involve sensitive supervision by superiors, but its most salient characteristic is the formation of informal, even "off-line" relationships that can go a long way to reduce the likelihood of burnout. The identification of such a support system, obviously, is inhibited by short durations in field placements. When placed in one agency for a longer period of time, students have less of a tendency to clump together, and to depend on faculty for support. The crucial point here is the degree to which students are accepted by the staff at the placement agency. If they are not fully accepted, then the less time spent there, the better in terms of the mental health of the student.

A significant problem with intensive assignment to placements is overcoming the effects of being supervised by an ineffective staff member, or a burned-out one, or one who tolerates students poorly. Of course, there is a ready remedy to the problem--move the student--but the remedy counteracts the benefit of the long-term placement by making it two short-term ones. Even moving a student from one area to another in the same agency creates culture shock problems, for there is a new group of people to work with, and so on.

A general rule is that the more skills there are for a student to become competent in, the longer the placement.

The model that seems to work reasonably well in Centennial College's Mental Retardation Counsellor Program is:

Semester 1 - no field placements--visits only
Semester 2 - one day per week in one agency
Semester 2½ - 4 week block placement (5 days per week) in one government facility
Semester 3 - one day per week in one agency
Semester 4 - four block placements (5 days per week)
- one week in nursing home
- three weeks in a multi-handicap setting
- eight weeks in a government residential facility
- eight weeks in a community-based service, usually but not necessarily residential

Although the above pertains to a training program that is based in an educational institution and whose graduates obtain employment in a variety of settings, I think the same issues are relevant to in-service training programs. It is, in my experience, a mistake to train people to function in only one setting. External placements must therefore be utilized, and the same arguments pertain.

Distribution of Placements in Curriculum. A student must be involved in the field during every semester of his/her training. This is to ensure that classroom material (often considered to be "merely theoretical") is tested immediately in the field setting. Results are discussed in conjunction with fellow students and faculty members in a way that enhances both experiences, and maximizes the possibility that cognitive material gets translated into skills, not merely behaviours.

A field placement should occur as close to the beginning of the training as possible, so that the student can "test out" his or her vocational choice, and at the same time enable the faculty to assess field performance early on. My own experience is that the first semester is too soon for recent high school graduates to have a placement, even one day per week. They feel quite incompetent and lost. Of course, this is an enormous generalization, and is not true for all 17 and 18 year old people. To overcome this problem, we have students arrange to visit and spend some time at one of several community-based residential programs serving people who are labelled mentally retarded. They usually put in about 6 hours over a semester. This, coupled with visits to other agencies, fulfills a basic orientation need without the problems associated with a formal placement. There is no evaluation, but the student writes a report of his/her experiences.

Centennial's 21-week block of four placements at the end of the program is not the ideal arrangement, in my opinion. It contributes to a sense of premature completion of training, and the periodic integrative seminars back at the college are sometimes seen as "academic" as opposed to "real". This is in spite of the experiential nature of the seminars. It seems to me that the ideal arrangement would be a learning block system that contains classroom blocks and placement blocks. The classroom block would consist of 4 days class and 1 day placement; the placement block would be 4 or 4½ days placement and ½ or 1 day class per week. The placement occurring during class blocks would not be carefully tailored to the concurrent curriculum (but would not be too advanced for the student). While the placement in the placement block would be designed specifically to reinforce the previous classroom work.

The block placements occurring in the placement block should be arranged so the student on practicum has ample opportunity to practice the set of skills just covered in the classroom portion of the curriculum, but care must be taken that the practicum setting does not allow the student to practice only a subset of the skills required of a residential advisor. This tends to work against the development of an integrated worker. For example, if the student has just completed a classroom block on counselling and group process, the ideal practicum setting is not one in which s/he would be able to spend 60% of his/her time doing counselling or facilitating groups. This is even more important if the staff in the placement setting do not spend a similar amount of time counselling. That is, if a block of students come into an agency for practicum purposes and wind up doing much different work than the staff, students will be alienated from staff, and run the risk of not being accepted even after graduation.

Identical vs. Varied Placements. The question to be answered here is "is it desirable for every student to get the same practicum experience?" One of the problems with a competency-based training program is that it tends to suggest that everyone coming out the other end ought to have had the same experiences and the same competence. That seems to me to be impossible. Two successive placements in the same ALA will result, probably, in two different placement experiences, because the staff may change substantially or subtly; the same is true of the clientele. If it is seen as desirable for students to experience as nearly identical placements as possible, there are a number of constraints. First, the size of the student body will be limited to the number of practicum students that can be accommodated at the smallest practicum setting. Second, students will have to be directly supervised for most of their practicum by faculty from the training program. This can have a substantial cost.

My own view is that placement settings within a broad group, such as multi-handicap settings, need not be very similar, as long as it is possible for the student to practice the sets of skills identified for that placement type. Since it is not possible to ensure identical placements for all students, the criterion for student success is the assessment of competence jointly by the student's supervisor at the practicum setting, the faculty member and the student. Allowance will have to be made for the varying competence levels of the agency staff supervising the student; this must be done by the faculty member concerned.

Establishing Field Placement Settings. Once the above questions have been resolved, you can now go into the field and select placements. I think that the major criteria for deciding to use a particular setting are:

- commitment of agency and the staff members who will give direct supervision;
- skills offered by the setting;
- quality of program;
- extent and quality of available supervision;
- freedom of operation allowed the student.

On a visit to the potential placement setting it is crucial to assess the value of students to the administration and to the direct care staff. While the administration may be very enthusiastic, the direct service folks may resent students mucking about in their territory. Or the administration may see students as the extra bodies who are able to lend a hand.

The potential placement agency must clearly realize the reciprocity inherent in such a relationship. Students take time to direct and supervise, and to evaluate. The agency, if it is fairly large, may have to appoint someone on staff to be the local student liason person, or at least given this responsibility to someone as a part-time job. (This arrangement works best if that person's salary is paid in part by the training institution.) At any rate, the agency must be aware of the requirements for orientation, supervision, evaluation, and the general care and feeding placement students need for a while. While it is true that students on practicum do render some service, that service should not be the overriding concern of the potential practicum setting.

Field supervisors of students (Co-op resident advisors) should be approached by the training institution as well as by their own employer to find out if they would like to work with a student. The administration of the setting may ignore the need to solicit supervisors if this is not done. Very little is more devastating to a student on his first or second placement than to be greeted with "What are you doing here? I didn't ask for a student!"

Field supervisors ought to be made to feel that they are providing the training institution with a valuable service, because they are. The field supervisor makes or breaks the placement experience for the student. It may be useful to think about some form of recognition for the field supervisor--an honorarium, a certificate, etc.

The field supervisor of a student ought not to be a person whose major function is administration, since that will result in the student being "delegated" to someone else, and frequently to several other people. This can result in contradictory feedback for the student, and contribute to a sense of non-support at the agency.

If the field supervisor is a direct service person, given the turnover rate in the field, that person may well never have had supervisory experience. If this is the case, it is necessary to provide some training for the field supervisor. And even those who have previously supervised someone often need some help. So the question here is not "do we train supervisors?" but "how do we train supervisors?" The most comprehensive way is to run periodic workshops for them, probably at the training institution. This would further convey to the field supervisor that s/he is valuable to the program. It is possible for each faculty member involved in field supervision to carry out the function of training field supervisors on an agency-by-agency basis; this is the most usual method. It does waste time, though, and unless the faculty member responsible for that practicum setting is very sensitive to the competence of each field supersisor, and diplomatic as well, the student runs the risk of poor supervision.

Areas that field supervisors may need information and/or training in can include:

- a detailed description of the training program;
- the place of their agency in the program;
- the specific sets of skills the training institution is expecting the student to demonstrate;
- how to orient students;
- what kind and amount of direction to give;
- how to fade direction;
- what kind and amount of feedback to give;
- what sort of relationship provides most growth for students at various points in the program;
- how much responsibility to allow the student;
- technical skills if required - program planning, behaviour management, counselling, physical management
- how to foster independence and professionalism

Contracts. Behavioural contracting has been used successfully in many applications It is useful here. It is desirable to have a contract between the agency administration and the training institution, in which the broad aspects of the placement are clarified. Such things as liability for injury to students or to clients should be specified, as well as the maximum number of students to be placed, and at what times. Statements as to the responsibilities of each party in terms of liaison, problem solving, supervision, evaluation and scheduling ought to be negotiated and written.

Perhaps more useful is the contract between one field supervisor, one student and one faculty member. Each of the three parties can contract for such things as: student responsibilities, faculty role, when and how much supervision is to be given and by whom, responsibility for evaluation, and like matters. The inclusion of these three parties, and only these three, personalizes the relationship as well as clarifies and formalizes it. At Centennial we are experimenting with this method this year; it is welcomed by most field supervisors. Each supervisor and each student are provided with copies of the various responsibilities they have agreed to.

Supervision of Field Placements. This section refers to the role of faculty members who have responsibility for field supervision. Every faculty member teaching in an ALA program should have some field supervision responsibilities. As well, no one should supervise field who does not also teach in the classroom. There is enough of a perceived dichotomy between classroom and field without exacerbating it. Additionally, the teacher in doing field supervision sees exactly how his/her material is being used by students (and staff); this assists in making the classroom experience more relevant and helps the teacher manage the teaching/learning situation to facilitate transfer of learning. Looking at it the other way round, the field supervisor can distill various field situations and bring them into the classroom where students can be exposed to the concepts and skills involved in a more controlled and unhurried environment, and with greater availability of resources (such as videotape) than is usually the case in the field.

The frequency of field visits by faculty should be based on several factors: faculty need for information, students' needs for contact with the training institution, students' needs for support, length of the placement, type of skills being sought in the field setting, and time constraints. More frequent visits are required for earlier placements, and for new field settings. For a one-semester, one day a week placement, three or four visits should suffice. It is important that the students not feel "dumped" into a practicum setting, and that field supervisors not feel that the training institution is leaving them to go it alone.

Even if field supervisors are trained, it is still essential that briefing meetings be held with agency staff; one last meeting is required just before placements begin, just to be sure that when students arrive at the door someone is expecting them and has some notion of what to do with them.

Roles of Faculty, Practicum Supervisor and Agency Field Supervisors. It is important that roles do not get confused. It is the function of the ALA agency field supervisor to supervise the student. In this model, the agency staff member is the one who has the daily responsibility for the student. As in any organizational structure, bypassing people courts trouble. The practicum supervisor works through the agency supervisor when possible for such things as making visitation appointments, negotiating student responsibilities and evaluation.

Evaluation sometimes becomes sticky. The faculty should ensure that the agency field supervisor knows the required criteria for the demonstration of competence. Once that is sorted out, evaluation is the agency's role. Otherwise, the training program gets no useful feedback on the adequacy of its preparation of students. The program could turn into a large and expensive self-fulfilling prophecy.

This is not to say that evaluation cannot be done jointly. Or that in some areas the faculty member may retain evaluation responsibilities. This can happen in an agency that, for one reason or another, is missing a technical skill, such as writing IPPs.

Self-evaluation by the student is required for the development of professionalism. The student should also be helped to articulate criteria for evaluating the placement agency on how well it has managed the placement learning experience.

There will occasionally be problem situations in which it is obvious that the agency field supervisor and the student have significant differences of opinion about important matters, such as the level of skill to be demonstrated, amount of direction or feedback to be provided, agency practices, or the relationship between the student and the supervisor. The practicum supervisor must take care here not to subvert the agency supervisor by trying to solve the problem directly with the supervisor at the first indication of a problem. The student should be directed to deal with his/her agency supervisor until that becomes impossible. Then the practicum supervisor can enter the situation as a facilitator. This encourages the student to develop the useful skill of taking care of oneself in an organization. The practicum supervisor must, of course, monitor the situation so that s/he can intervene at the right point.

The Ideal Placement Setting. Somewhere one must exist. The more of the following characteristics a placement setting has, I think, the closer it approaches the ideal.

- it views students as useful, fun, a break from established routines, refreshing;
- it commits itself to excellence in fulfilling its training responsibilities;
- it provides the skill areas it contracts for;
- it provides the supervision it contracts for in a sensitive and growth-producing manner;
- it orients students early, and helps them begin to function as quickly as possible;
- it allows the student the dignity of risk;
- it gives students responsibility;
- it treats students as professionals in training;
- it sees faculty members as resources;
- it makes a commitment to competence, both for students and for staff;
- it allows students a variety of experience;
- it listens nondefensively to ideas from students;
- it allows students some elbow room.

An excerpt from the Mental Retardation Counsellor Program Field Placement Manual and Program Description[1] is shown below to provide a detailed working model of field placement procedures.

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[1] Mental Retardation Counsellor Program Field Placement Manual and Program Description. David W. Sigetich, Michael Evans, Patricia LeBlanc, & Janis Goodmurphy, Mental Retardation Counsellor Program, Centennial College of Applied Arts and Technology, 651 Warden Ave., Scarborough, Ontario, 1979. Used with permission.

# ABOUT FIELD PLACEMENTS

A field placement is the placement of a student in one or more situations that simulate or directly reflect the nature of the field for which the student is being trained.

A student on field placement is to be distinguished from:

a) a fully-trained person
b) an employee
c) a volunteer
d) a program aide
e) an assistant.

A field placement has specific objectives determined by the College and negotiated with the placement agency. These objectives are learning objectives. In order for learning to take place in a field placement, the student must be given opportunities to perform various behaviours, and receive feedback on his/her performance. This clearly distinguishes placements from employment, in that an employee is being paid, assumes responsibility, and is expected to be fully trained.

Field placements form an integral part of this program and other programs in the Community Services Department.

Students are expected to attend their placement regularly and punctually, as part of professional training. Placement time lost due to absence or illness must be made up with the agency involved, subject to confirmation by the College. Chronic lateness or absence will constitute a failure for that placement.

It is desirable for students to experience the full work schedule of regular staff. Consequently, program policy is to have students attend placement for the same days and hours as their supervisors.

## Advantages of Field Placement

For the Agency:

- the agency contributes to the training of workers in the field
- the agency has an opportunity to assess prospective employees in a very real and intensive way
- the agency is subjected to the views of a relative outsider, someone who has a different picture, thus presents new ideas and challenges
- the agency has access to college faculty, who have some degree of training and expertise.

For the Student:

- the student's exposure to the field is augmented
- the student has a better chance to integrate "classroom" material with actual problems and techniques

- the student comes into contact with professional workers on the job, which tests him/her as a worker and encourages further professional development
- the student is provided with specific feedback about his/her performance, thus helping in the process of building strengths and overcoming weaknesses
- the student assesses his/her own performance and compares it to professional workers
- the student gains practical experience which, although not "work" experience, is a significant advantage in obtaining employment.

## ABOUT EVALUATION

### GENERAL

Evaluation consists of several steps to make it most useful. The first point of evaluation is to give the student feedback on his/her performance in order that she/he may change. Secondly, evaluation is used as a means of assessment, in terms of assigning a grade.

Evaluation, then, consists of:
1) identifying student performance
2) comparing performance with requirements
3) discussing performance with the student
4) formal, written assessment

The on-going process (Steps 1 - 3, above) should occur as often as possible; certainly not less often than once per week. This time (often called supervision) can be used constructively by the student to hear your requirements and adjust his/her behaviour accordingly.

Formal assessment or evaluation is done as a tying-together process, and is not designed primarily to help the student change. Consequently, anything that appears on final evaluation forms must already have been discussed with the student. The final evaluation is essentially a snap-shot of the student's performance at the end of the placement.

You may wish to do a written evaluation half-way through the placement. You will probably find that your student will welcome this process. Use either your own form, a narrative, or our forms. If you use our forms, be certain the form is marked INTERIM EVALUATION.

In using the Subjective Evaluation (shown in Appendix F), please feel free to add additional evaluation areas and comments on Question No. 12. You may or may not find the scale of 1 to 10 helpful. We must translate your comments into a grade for the student, so we included the scale. You need not use the scale if it offends you, but please try to use it. This evaluation form must be discussed with the student before the end of placement. She/he must sign it; the student may add his/her comments on the last page. You must also discuss the student's Self-Evaluation (shown in Appendix G) and sign it prior to the end of placement.

It is imperative that the College receive evaluation forms in time to compute grades, and, from a second-year student, so that he/she can graduate with his/her classmates. If evaluation forms are not in, it may hold the student back one year, due to the deadline for graduation.

We must receive evaluations by:

MR 203-3: April 27, 1979
MR 204-4: June 1, 1979
MR 308-L: June 1, 1979

Any later doesn't help.

## FIRST YEAR STUDENT

Read the First Year placement Objectives before you evaluate a first-year student. The objectives are fairly general because the placements are varied as to their activities. You may certainly set up your own objectives with the concurrence of the faculty member supervising the placement. The evaluations to be used are: Subjective Evaluation and Self-Evaluation.

## SECOND YEAR STUDENTS

The objectives of the second year placements are contained in the appropriate Competency Checklist (shown in Appendix H) and in the Course Description for MR 308-L (see part 4 of this chapter). Each placement agency must use the appropriate Competency Checklist at least for the final evaluation, if not the interim evaluation. In addition, the Subjective Evaluation must also be used. Certain competencies may appear not to apply in your particular area. Before you decide not to assess them, please check with the college practicum supervisor.

The Competency Checklist is behavioural in orientation. It is designed to pick up the student's performance of concrete, observable behaviours. Most of those behaviours do not lend themselves to scaling. For example, you either fill out an AFI assessment correctly or you do not. There is no middle ground. Consequently, the scoring key has been modified from previous years to include only:

C = Competent
O = Not Competent
E = Exceeds Requirements

What does "competent" mean? That is difficult to answer, because it may mean one thing for one skill and something else for another. Also, each placement supervisor will probably have somewhat different notions of competence. This is, of course, exactly the situation an employee faces when he/she is working. Your supervisor may have a relatively clear set of expectations of you, but if he/she were to be replaced by another, your behaviour may have to change. This is not to say that one of your supervisors is wrong and the other right; they are merely different. We recognize that this will be the case, and will not try to impose some arbitrary definition of competence on you. We do have some notions as to what constitutes competence.

> The student (RA trainee) will carry out some activity that has value to the client and/or the agency in such a way that it does not have to be redone, it does not have to be corrected or improved, and the client and/or agency actually derive some benefit. In carrying out the activity, the student needs little if any supervision beyond that normally given to competent, trained staff members.

In order to complete each placement successfully, the student must be assessed competent in each of the major skill areas on the Competency Checklist. Failure to be so assessed will result in the student either having to repeat the placement or be terminated from the program.

There is occasionally a tendency on the part of placement supervisors to "be easy" on the student, to assess a student as competent when such is not the case, merely to help the student get through. This practice does no one any favours, especially retarded people. If a student graduates when she/he is not competent to meet the needs of people who are mentally retarded, the client, the College, and the employing agency all suffer. The College must rely on you to provide accurate data on student performance. Without your commitment to insisting on competent performance, field placement becomes meaningless. We are counting on you as the source of reliable information about students.

## FIELD PLACEMENT LOGS

## MR-203-3, MR-204-4, MR-308-L

The purpose of a field placement log is not merely to catalogue a list of your activities, but to document your growth and change in terms of how you perceive people and situations, how you cope with them, what learnings you discover, new ways of using (integrating) your learning, problems you have in field placements (with clients, peers, staff, faculty) and how you deal with them.

For each field course you should purchase an 8½ x 11 hard or soft bound writing tablet, such as Campus Exercise Book #3369 or 3370. The front cover should contain your name, student number, the course number, placement agency, supervisor's name, and the dates of your placement.

Page 1 - your name and the name of the agency; list of assigned duties

Page 2 - assigned duties, con't.

Page 3 - actual duties - there is often a difference between what you are formally assigned to do and what you actually wind up doing. During the course of the placement, as you find this to be true, fill in pp. 3 and 4 with these other duties.

Page 4 - actual duties, cont'd.

Page 5 onwards - a day-by-day entry. Start each day on a new page; one page per day should usually be sufficient. In this section describe any out-of-the-ordinary things that you did, if any. In addition, each daily entry should be done on a Significant Event (SE) basis. That is, for every day in placement identify one significant event in your day. "Significant" is up to you to define - also what you perceive to be important. For each SE, describe what occurred and why it is significant, and to whom. Then write about the SE - what you felt about it, thought about it, will do about it; what you learned, flashes of insight, implications for your work or growth, changes in your approach--whatever took place.

This is essentially a diary of your thoughts, feelings and learnings. To be valuable it must be done one day at a time; DO NOT try to go back and recapture thoughts and feelings from two or three weeks past. Keep it current. An SE could relate to you alone, to you and a client, you and a staff or faculty member; it could happen during the regular course of your daily placement activities or it could be a departure from the normal routine. It should be related to you as a helping person.

The log must be handed in to a faculty member before the end of placement. It will also be checked and reviewed periodically.

Your field placement supervisor has been informed that you are keeping a log.

Logs must maintain the confidentiality of both the clients and the staff of your placement agency. Names of persons you refer to in your log must be disguised in order not to breach confidentiality.

Questions or concerns you may have about situations can be noted in your log; this will serve as a reminder to you to discuss them with your placement supervisor and your faculty supervisor.

## FIRST YEAR FIELD PLACEMENT OBJECTIVES

The intention of the first year field placement (MR-203-3) is to provide the RA trainee with exposure to some of the work activities presently involved in providing service to specific ALA client populations. Therefore, it is anticipated that the student will engage, for the equivalent of 8 hours per placement day, in activities already established by the agency normally carried out by staff. This is to say that students would be involved in helping carry out existing programs or assisting in establishing and implementing new programming.

Students are not expected only to perform tasks that are viewed as unpleasant, unnecessary, or intended only to ease staff pressure. It is understood that some such activities are always involved as a part of normal staff functions. However, this should not be the main focus of placement activities. As this placement is intended to allow students to gain training in direct service, the agency should attempt to provide a well-balanced exposure to as many staff activities as possible.

As well, students are expected to realize that not all activities in which they are requested to engage are necessarily pleasant or enjoyable.

It is understood that a one-day-per-week placement is limited, particularly in allowing for continuous client contact. Students should be involved in program activities that are amenable to the amount of client contact afforded by this placement.

The RA trainee will:

a. Identify services available to clients and the manner in which service is delivered at the field placement agency.

b. Continue training in providing direct services to a number of service recipients, under close supervision.

c. Identify how that agency relates to other agencies in the community.

d. Obtain feedback on performance from agency personnel and clientele.

e. Evaluate their performance at the agency in relation to clients and staff as well as the value of the placement in relation to professional development, using agency feedback data, instructors' inputs, and personal perceptions.

## COLLEGE RESPONSIBILITIES

1. To train workers in the field of developmental disabilities. Field placement agencies are used to enable the student to acquire some skills, and refine others.

2. To specify placement objectives. These are communicated to the agency and negotiation takes place as to how the objective can be accomplished. In some cases a specific objective cannot be met at a placement; the college reserves the right to delete objectives. For second-year students the objectives are contained in the Competency Sheets, as found elsewhere in this package.

3. To establish placement parameters (e.g., length, dates, hours of placement, etc.). The policy is that the placement should conform closely to the actual demands of the agency (i.e., if the normal work week entails working evenings and weekends with days off during the week, under normal circumstances the student will attend placement during the normal work hours of his/her supervisor). Students are not required to attend placement during College holidays. However, the student may volunteer to attend placement those days as part of an ongoing program.

4. To select placement agencies and negotiate responsibilities.

5. To screen students. This is generally only done at the request of an agency. Students normally select their own placements. Some attention is paid to our perceptions of the student's suitability for a particular placement.

6. To advise agency of potential concerns about a student. If a student requires more supervision or has a difficulty of which we are aware, we will communicate that fact to the placement agency.

7. To establish and maintain liaison with placement agency, both to share our perceptions about the agency and its programs, and to monitor the student's placement in terms of attainment of objectives and various skills. The faculty member can serve as a communication-facilitator between student and his/her supervisor. The College has a responsibility not to interfere in the operation of an agency, but to help the student and supervisor communicate and solve problems if required. Faculty members are "on call" during the day and can be called upon whenever a question or concern arises. It is most helpful to clarify questions or problems as early on in a placement as possible.

8. To grade the student. Evaluation forms filled out by the agency and by the student are the most important sources of data. Some judgment must be made by the college to account for the different requirements and standards among agencies.

9. To provide placement agency with general feedback about students' placement experience. Specific data can be obtained by the agency from each student.

## STUDENT RESPONSIBILITIES[2]

Student responsibilities include:

1. Attending a particular placement in accordance with stated program requirements.

2. Utilization of assigned resident advisor monitor.

3. Determining jointly with practi[illegible] agency, an appropriate schedule for placement.

4. Utilize and initiate, as necessary, the assistance of appropriate placement personnel and college faculty.

5. Gaining an understanding of the reasons for the agencies' methods and activities.

6. Maintaining a sense of involvement in the agency on an ongoing basis. This includes following stated agency procedures. A significant breach of agency procedures may be grounds for termination of the placement and resulting failure for that placement.

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[2] Adapted from MR Counsellor Program Field Placement Manual, David Sigetich, et al., Centennial College, Ontario, 1979.

7. Pursuing appropriate channels of handling problems as they arise. Should the student experience difficulty on placement, he/she should first consult his/her CO-OP resident advisor monitor (ALA agency supervisor). If the problem remains unresolved, the practicum supervisor should be consulted at which point other agency personnel will be considered for consultation.

8. Attendance. 100% attendance and punctuality is expected for those times assigned for the placement, excepting valid medical reasons or personal emergencies. If the student is unable to attend the placement, both the practicum supervisor and the CO-OP monitor must be telephoned and informed. Should the supervisor require the student to make up time as a result of absence, the student is required to initiate such arrangements in conjunction with the practicum supervisor. Failure to arrange make-up time will be considered as a failure for that particular placement.

9. Confidentiality. The student is expected to comply with the confidentiality policies of the placement agency and to use professional discretion in any discussion concerning placement activities and experiences.

10. Self-evaluation. The student is responsible for filling out a self-evaluation form and presenting the responses to the immediate supervisor for consultation and signature prior to the completion of the placements.

11. Seeking evaluation. It is the joint responsibility of the trainee and supervisor to insure feedback of performance to the trainee. Should this not occur for any reason, the student is responsible for securing this information from the practicum supervisor. Failing this, the Project Director should be advised.

12. Transportation. Securing and financing required transportation to and from the placement agency is the responsibility of the student.

13. Holidays. Students are not expected to be in their placements during College holidays. Individual arrangements can be made with the student, however, to attend placement at these times if prior commitment on the part of the student has been established. Such commitment is considered voluntary.

14. Field Placement Seminars. Students are expected to attend scheduled field placement seminars at the college. Should the student be unable to attend, he/she is responsible for telephoning and notifying the placement supervisor.

15. Students are required to consult with supervisors regarding all evaluation forms. The student must sign all such evaluations and indicate disagreements in writing on the evaluation form prior to the end of the placement.

16. Placement Log. The student is responsible for maintaining a log of placement experiences. Consultation between student and supervisor regarding content of the log is suggested.

17. Students must complete any placement evaluations used by the placement agency.

18. Students must complete evaluation forms and other project forms (e.g. pre-tests, post-tests) given them by project staff and instructors. Failure to complete such forms will result in termination from the project.

## AGENCY RESPONSIBILITIES

1. Select CO-OP monitor field supervisors for students. CO-OP supervisors should want to work with a student, rather than being assigned the function. A supervisor should be trained and have some supervisory experience. The ideal supervisor is not primarily an administrator. The supervisor and the student should work the same shift and day off pattern.

2. Orient students. The agency should prepare an orientation experience (including print and live inputs) that will ensure an adequate knowledge of the agency and its services by the middle of the placement. This should include all procedures the student is expected to follow.

3. Supervise students. The agency must ensure adequate direction and supervision for student learning. The amount of direction required is determined by (a) the level of the student (i.e., first year or second year), (b) the judgement of the supervisor, and (c) the ability of the student. Supervision in this context means the reviewing of a student's performance. Supervision should occur daily, whether or not there is a specific agenda. The student must be given the opportunity to receive feedback from the CO-OP as often as required.

4. Provide a useful learning experience. It is expected that a distinction will be maintained between the role of student, volunteer, program aide and employee. A student is to be considered a "professional in training". The duties assigned to a student must reflect the objectives of the placement, and the appropriate competency sheet (for second year students).

5. Evaluate students. Forms have been provided for this purpose. The forms generally represent final evaluation. During the course of the placement it is expected that informal evaluation will occur during daily supervision. It is the responsibility of the college to grade students; however, the grade must be based on information provided by CO-OP to have any meaning at all. The evaluation must be as frank as possible in order to convey to the student and the college an accurate picture of the student's performance. During visits made by practicum supervisor, the on-going supervision and evaluation will be discussed, interim evaluation may be done in the middle of a placement; competency sheets have space provided for this purpose.

   It is the responsibility of the CO-OP to ensure that the Subjective Evaluation, and the Competency Sheet for second year students reach the practicum supervisor. They can be handed to the practicum supervisor on his/her next visit or mailed. All evaluation forms must reach the college before the end of the current semester. Feel free to add comments and/or other areas for evaluation. It is expected that the field placement agency will obtain written consent of the student on the evaluation form before copying the form for its own records. Evaluation material is CONFIDENTIAL and must be so treated. Evaluations must be completed and signed by CO-OP and student prior to the completion of the placement.

6. Maintain liaison with college. The practicum supervisor may be consulted at any time, and should be advised of difficulties or problems. The first step in problem resolution is the student and his/her CO-OP meeting and attempting a solution. The second step is calling in the practicum supervisor. Students are not to subvert this process by going directly to the practicum supervisor before attempting to resolve the problem with their CO-OP. The practicum supervisor will negotiate with each CO-OP convenient visiting times. Liaison should also occur around the specific placement objectives.

7. The agency is responsible for ensuring that a qualified staff member supervises the administration of all medications.

8. The CO-OP may wish to review the student's log periodically. Review and discussion is encouraged.

## GUIDELINES FOR STUDENT ORIENTATION

These are the topics we believe must be covered with a student in order to ensure the student is able to function in your agency.

The topics listed below should probably not be covered all on the same day.

1. Student's Placement Area:
   - what it is, where it is
   - how it fits into agency
   - student duties and responsibilities
   - supervision arrangements
   - introduction to supervisor
   - evaluation--what, when
   - hours of placement

2. Tour of ALA
3. Introduction to other key staff
4. Introduction to clients
   - who they are
   - where they are
   - what programs they are involved in
   - where they come from
   - where they are going

5. History of the agency (abridged)
6. Current services and programs offered by agency
7. Policies and procedures
8. Emergency procedures

# PART 4: MENTAL RETARDATION COUNSELLOR PROGRAM - A Sample ALA Training Program[1]

## COURSE DESCRIPTIONS

1978, 1979

* * *

David W. Sigetich, M. Ed.
Program Co-ordinator
Michael A. Evans, M. A.
Teaching Master
Patricia LeBlanc, B.N.
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[1] Used with permission.

## Mental Retardation Counsellor Program

### General Information

The Mental Retardation Counsellor is a specialist trained to work with children and adults considered mentally retarded. In response to the unique social and personal problems of this group of people, the Mental Retardation Counsellor seeks to help individuals become more adept at meeting their own needs, coping with our society, and becoming more independent. Typical professional activities include the responsibility for designing and implementing programs for individuals in residential settings such as government facilities, community residences, and independent homes and apartments, in order to assist the personal development of service recipients. Such training programs include self-care skills, social interaction, prevocational and vocational skills and habits, use of leisure time, and community skills, among others.

In addition, the Mental Retardation Counsellor is involved in personal counselling with clients as well as providing supportive physical care for those requiring such assistance.

The program consists of two ten month academic years, including field placements during the year, a three week field placement at the end of the first year (outside Toronto), and a five month field placement in the second year, some of which is outside Toronto. The program focuses on practical, specific knowledge and skills built on a sound foundation in the behavioral sciences.

Students will take courses in general psychology, mental retardation, counselling approaches, program strategies, group dynamics, basic health care, development of the person, and others.

## CAREER INFORMATION

Graduates can expect employment at competitive salaries in public facilities and in the growing number of community agencies, residences and workshops.

One major employer of Mental Retardation Counsellor graduates is the Provincial government through their residential facilities for the retarded throughout Ontario.

The other major employers of M.R.C. graduates are the local associations for the Mentally Retarded; in Toronto, The Metro Toronto Association for the Mentally Retarded.

Salaries are usually competitive, and there is opportunity for advancement to supervisory and management positions on merit. This program is not directed towards teaching in the school systems.

## OUTLINE OF PROGRAM SEQUENCE - MODEL ROUTE (9/78)

### SEMESTER I

| | |
|---|---|
| EN 101-3 | The Art of Making Sense I |
| CS 220-1 | Introduction to Community Services |
| PY 101-3 | Introduction to Psychology |
| CS 221-1 | Human Growth and Development |
| *MR 201-2 | Introduction to the Field of Mental Retardation |
| *MR 202-3 | Mental Retardation |
| *CS 217-2 | Health and Illness |
| CS 223-1 | Principles of Program Planning |

(16 Credits, 24 class hours)

### SEMESTER 2

| | |
|---|---|
| EN 102-3 | The Art of Making Sense II |
| *MR 205-2 | Health Care |
| PY 201-3 | Abnormal Psychology |
| *MR 302-3 | Program Strategies with the Mentally Retarded |
| *MR 203-3 | Field Placement I |
| Elective | General Education |
| CS 222-1 | The Family |

(18 Credits, 21 class hours plus 1 day placement)

### SPRING

| | |
|---|---|
| MR 204-4 | Field Placement II - 4 credits |

### SEMESTER 3

| | |
|---|---|
| PY 308-3 | Behavior Modification |
| CS 204-3 | Group Dynamics |
| *MR 304-3 | Counselling Approaches |
| *MR 309-1 | Supervision and Administration |
| Elective | General Education |
| *MR 310-2 | Advanced Program Strategies |
| *MR 313-1 | Mental Retardation and Abnormal Development |

(16 Credits, 22 class hours + ½ day placement)

### SEMESTER 4

| | |
|---|---|
| *MR 308-L | Field Placement III - 21 credits |

TOTAL CREDITS - 75

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* requires "C" minimum grade

## COURSE DESCRIPTIONS

### SEMESTER 1

### EN-101-3, The Art of Making Sense 1

The Art of Making Sense is a two-semester course which gives instruction in clear and effective thinking, speaking and writing; in library research and documentation; and in the reading and analysis of carefully selected works of literature, both general and professional. (The student entering the College will be directed into the level of study most appropriate to his language needs.)

4 Hours/Week (64 hours)

### PY-101-3, Introduction to Psychology

To help the student become a better informed, more understanding and more questioning observer of human behavior. Given the fact that everyone already uses psychology, the course is designed to help people use it better--by distinguishing between the over-simplifications of popular psychology and the data concepts deriving from the indepth studies of psychology as a formal field of study.

4 Hours/Week (64 hours)

### CS-220-1, Introduction to Community Services

This course will expose the student to the theory and structure of government, volunteer, and private service offered in the community by institutions, agencies and private business. The course focuses on how these services attempt to meet needs expressed in a variety of types of communities. As well, basic service structures of Municipal, Provincial and Federal governments are outlined.

2 Hours/Week (32 hours)

### MR-201-2, Introduction to the Field of Mental Retardation

Students will investigate services available to the mentally retarded by field visits, agency interviews and guest speakers. Qualities of the "ideal" service system (the community) will be discussed. Legislation affecting the lives of mentally retarded people will be studied, and current issues in the field will be discussed, including normalization, deinstitutionalization, sterilization.

3 Hours/Week, (48 hours), field trips

### MR-202-3, Mental Retardation

An intensive study of those of us who differ significantly in intellectual and adaptive development, this course will consider the origins and maintenance of attitudes about people who are mentally retarded, some of the many causes of retardation, history of care and treatment, the nature and measurement of intelligence and adaptive behavior, perspectives on retardation, prevention of retardation, and some related conditions such as autism, emotional disturbances, learning disabilities, and other handicapping conditions.

4 Hours/Week (64 hours)

## CS-217-2, Health and Illness

This course will focus on health care knowledge that is required by a Mental Retardation Counsellor in the residential setting. Such areas include basic knowledge of the structure and function of the body, signs and symptoms of illness, and an introduction to pharmacology.

3 Hours/Week (48 hours)

## CS-223-1, Principles of Program Planning

This course will introduce the student to the skills involved in individual behavioral assessment. Operational observation of behavior as well as consideration of a number of formal behavior assessment tools, is stressed. Assessment scales considered include: the A.A.M.D. Adaptive Behavior Scale, The Adaptive Functioning Index, The Portage Guide, the Basic Life Skills Inventory, and the Progress Assessment Chart. Students will have an opportunity to practice observation and testing skills through activities and projects.

2 Hours/Week (32 hours)

## CS-221-1, Human Growth and Development

This course will cover the different stages of human growth and development; the parameters governing, the variables influencing, and the theories outlining each stage of "normal" human maturation.

2 Hours/Week

## SEMESTER 2

## EN-102-3, Art of Making Sense 2

See EN-101-3; includes a vocational component tailored to the requirements of various Community Services programs.

4 Hours/Week (64 hours)

MR-205-2, Health Care

This course provides knowledge basic to the physical care skills (which are taught in the Family Care Module of MR-308-L) required of a Mental Retardation Counsellor. The student will continue the study of the structure and function of the body and essential pharmacology; essentials of good nutrition and principles related to the administration of noninjectable medication will be covered. Included in this course is First Aid Training at the Red Cross Standard level.

3 Hours/Week, (48 hours) (including 18 hours First Aid)
Prerequisite: CS-217-2

MR-302-3, Program Strategies with the Mentally Retarded

(This course continues theoretical and practical consideration of the programming process begun in Semester 2. Students in this course will learn and actually practice skills related to the design and implementation of individual program plans (IPP's). Topics discussed include normalization and programming, the role of the programmer and program evaluation. Guided skill practice will be given in the following areas: program priority setting; baseline measurement and data collection; data display; goal setting and time-tags; task-based, criterion-based and prompt/fade programs; Task Analysis; writing a program; implementing a program. In conjunction with MR-203-3, aspects of the program process will be applied in a field placement setting.

4 Hours/Week (64 hours)
Co-requisite: MR-203-3

MR-203-3, Field Placement 1

In carefully selected field placements the student will spend one day per week working under the direction of trained staff members giving direct service to people who are mentally retarded. Faculty members also participate in student supervision. Typical placements include schools, sheltered workshops, adult development programs, employment training programs, residences, and assessment centres (Surrey Place Centre). A one-hour-per week integrative seminar will allow students to discuss issues arising from placement experience as well as consideration of relevant current topics related to working in the field.

Placement - 1 day per week (105 hours)
Seminar - 1 hour per week (16 hours)
Co-requisite: MR-302-3

CS-222-1, The Family

This course will define the family, study each of the different developmental stages, and examine the role of the family in society and its impact on individual family members.

2 Hours/Week

Prerequisites: None
Co-requisites: None
Special Requirements: None

Spring (May - June)

MR-204-4, Field Placement 2

A concentrated, block placement in a government facility for the mentally retarded. Students will be placed in residential areas with children, adolescents or adults of varying developmental levels and will be expected to perform residential duties under the supervision of trained personnel and college faculty. Typical settings include D'Arcy Place (Cobourg), Pine Ridge (Aurora), Oaklands Regional Centre (Oakville).

4 Weeks block placement (105 hours)
Prerequisites: MR-203-3, MR-302-3

SEMESTER 3

PY-308-3, Behavior Modification

The course intends to study the concepts and practice of Behavior Modification including research design, operant and classical conditioning, progressive relaxation, desensitization and flooding, modeling and vicarious conditioning, bio-feedback, hypnosis, self-modification and ethical practice. The course includes one-half day a week practicum in a behavior modification setting. By the end of the course, the student will be able to apply the principles of behavior modification.

3 Hours lectures and half-day practicum/week
48 hours classroom - 48 hours practicum
Co-requisites: PY-101-3

PY-201-3, Abnormal Psychology

This course is designed to give the student a systematic presentation of the concepts related to psychopathology and personality disorders with special emphasis given to function causation and general psychological principles. Various behavior patterns are described and illustrated. The student will be encouraged to develop an independent study project relating to the field of mental illness.

4 Hours/Week (64 hours)
Prerequisites: PY-101-3

CS-204-3, Group Dynamics

The student will, by experience, reading and theory input, learn about himself in relation to others, and about the nature, development and functioning of groups.

4 Hours/Week (64 hours)

## MR-304-3, Counselling Approaches

This is primarily a skills-practice course, as well as a "theory" course. For the duration of this learning experience, students will be required to counsel one other student weekly. Classroom work will consist of theory input and discussion focusing on the nature of the helping relationship, the needs of the counsellor and how they help and hinder the process of helping, stages of relationship, beginning and ending a counselling relationship, counselling parents, referring clients, Transactional Analysis and ethics. Guided skill practice will be given in active listening, paraphrasing, discriminating between affective and cognitive content, summarizing content, clarifying content, reflecting affect (feelings), accurate empathic understanding, surfacing, nonverbal communication, appropriate confrontation and contracting. Students will also present seminars/demonstrations on selected topics, including sexuality, power and authority in counselling, Parent Effectiveness Training, existential therapies, gestalt, Rational-Emotive Therapy, and others.

4 Hours/Week (64 hours)

## MR-307-1, Advanced Program Strategies and MR-310-2

Students will further develop their programming skills in such areas as: physical activation, gross motor, fine muscle, self-help skills, prevocational and vocational training, money management, cooking skills, use of community resources, recreation and infant stimulation. The course stresses creative programming alternatives, and allows the student extensive program writing experience using both hypothetical and actual clients.

2 Hours/Week (32 hours)
Prerequisite: MR-302-3 and MR-203-3

## CC-313-1, Abnormal Child and Adolescent Development

This course focuses on the abnormal development of children and adolescents from the physical, mental, emotional, and social aspects of development. Particular consideration is given to the interaction between mental retardation and various other conditions of abnormal development.

## SEMESTER 4

## MR-308-L, Field Placement 3

This placement is the focus of the entire program. It is divided into 4 training modules in which different skills and/or client populations are stressed. All placements are in field agencies; 4 integration seminars occur during the semester. Students are supervised by personnel trained in their fields; faculty, supervisors and students share responsibility for the evaluation of students. Students are required to demonstrate professional applied competence in a comprehensive range of skill areas.

The Family Care Module focuses on basic healthcare skills; students spend some time at one of Centennial's nursing campuses, and the rest of this two-week block is spent in applied settings such as nursing homes. Supervisors typically are qualified at the B.N. level.

The Multi-Handicap Module concentrates on physical care and programming skills applicable to persons who, in addition to being mentally retarded, are also physically handicapped--blind, deaf, spastic, C.P., paraplegic, hemiplegic, and combinations of handicaps.

There are two Residential Modules of 8 weeks each: one occurs in a government facility for the Mentally Retarded (see list under MR-204-3); the other occurs in residences operated by Metro Toronto Association for the Mentally Retarded, York Central Association, Brampton Association. Some other services are utilized, such as MTAMR's, Adult Protective Services Department, Salvation Army's Broadview Village.

## Modules and Skills

Family Care Module - 2 weeks (first placement) SKILLS:

1. Handwashing (proper procedures)
2. Bed Making: occupied, unoccupied; proper body mechanics, adheres to principles of microbiology, ensures client is safe and comfortable.
3. Assesses and records accurately: pulse, temperature, respiration.
4. Provides hygenic care: bed bath, mouth, dentures, hair, eyes, nails.
5. Feeds a resident.
6. Lifts and moves resident in a safe, comfortable manner, utilizing proper body mechanics: from floor to bed or chair, from one side of bed to another, from bed to chair and vice versa, up in bed, from supine to sitting, from sitting to supine, into and out of a bath tub.
7. Positions a resident using appropriate devices in the position of: Fowler's, supine, lateral.
8. Tests urine for sugar and acetone.
9. Prepares and administers: eye drops, eye ointments, suppositories.
10. Prepares and administers and records: tablet medication, liquid medication.
11. Places a resident on a bed pan and removes.

12. Identifies and explains the equipment required for: administration of oxygen, administration of fleet and soapsuds enemas, suctioning, shampoo in bed, application of heat, application of cold.

13. Demonstrates: administration of oxygen, enema, suctioning, shampoo in bed, application of heat, application of cold.

14. Changes a dressing and care of decubitus ulcer.

Multi-Handicap Module - 3 weeks. Placement settings include McCordic School, Beverley Street School, Ontario Crippled Children's Centre, Glenholme-Maplewood Developmental Centre (Oshawa), Participation House (Markham).

SKILLS:

1. Identifies symptoms, results and appropriate care for selected physical handicaps.

2. Uses appliances appropriately: wheelchairs, walkers, crutches.

3. Uses appropriate lifting and moving techniques.

4. Positions properly: to prevent contractures, for comfort, for maintenance of proper body posture.

5. Cares for prostheses: artificial limbs*, false teeth*, hearing aid, eyeglasses, braces*.

6. Teaches care of prostheses.

7. Uses comfort devices: trochanter rolls, pillows, etc.

8. Initiates relaxation procedures.

9. Recognizes and provides appropriate care following epileptic seizures: grand mal, petit mal, psychomotor.

10. Provides required hygiene.

11. Uses appropriate feeding techniques.

12. Teaches self-help skills: dressing, toileting, grooming.

13. Performs exercises: passive, restive, active assistive.

14. Initiates low organization games.

15. Helps develop sensorimotor skills: body awareness, space and direction, balance, limb coordination, basic locomotion, crawling, walking.

16. Encourages social skills: awareness of others, contact with others, interaction with others, cooperation with others.

* where applicable

Residential Modules - two blocks of 8 weeks each, one block in a government-operated residential facility, one block in a private or association-based residential service.

SKILLS:

1. Use basic counselling skills: make contact with client, identify and respond to feelings, attend and respond to non-verbal cues, listen actively to client, utilize appropriate techniques for disturbed behaviors, detect and handle transference, clarify role expectations, maintain a proper balance of involvement, initiate and maintain nondependent relationships, demonstrate empathy, demonstrate genuineness, demonstrate warmth, demonstrate respect, demonstrate concreteness, demonstrate appropriate confrontation, demonstrate alternative identification and evaluation with client, keep appropriate records, counsel client regarding sexuality, counsel client regarding changes in living/working situation, counsel a group, phase out relationship appropriately.

2. Conduct programs to meet individual needs: obtain all relevant program information, perform behavioral observations, assess client using appropriate assessment scale (ABS, AFI, PAC, CPPC, BLS, Portage), identify program priorities with team and client, utilize goal-setting method, establish baseline, consult with other staff as required for goals and design (psychologist, physician, nurse, physiotherapist, etc.), implement task analysis, identify methods to be used, design program in writing, following placement agency guidelines, obtain commitment from client, implement program, evaluate program, adjust program as required, maintain accurate records using appropriate charts, write up program results, participate in on-going programs.

3. Utilize behavior modification procedures: establish baseline, identify terminal behavior, identify target behavior, identify reinforcers, identify balance of consequences, establish reinforcement schedule, utilize appropriate techniques (shaping, chaining, fading, extinction, time out, desensitization), evaluate program effectiveness, keep accurate records.

4. Contribute to program development/implementation: attend to personal care needs of client, instruct in personal care skills, instruct in meal preparation, instruct in community orientation skills, instruct in housekeeping skills, instruct in laundry skills, plan a weekly menu using good nutritional principles, assist clients in shopping and budgeting, assist in language stimulation, encourage age-appropriate behavior.

5. Contribute to client's physical health: observe, report and record signs and symptoms of illness, attend to needs of persons who are epileptic, describe medical history and current treatment for each client, prepare noninjectable medications according to agency policy, adminster noninjectable medications properly, record accurately according to agency policy, demonstrate use of records for control and narcotic drugs, classify medications administered, identify side effects for medications administered, complete 10 drug studies.

Residential Modules, Cont.

6. Function as a team member: consult other staff concerning goals, priorities, methodology, etc., participate in client conferences, communicate concerning client (to counsellor, orally, daily written records, occasional records), involve client's family as appropriate, use appropriate formal and informal channels of communication, assume responsibility with counsellor for house administration.

7. Know agency: identify person/body in charge of agency, identify services provided on site/off site, identify relevant controlling legislation (if any).

Further details regarding criterion and competencies required in each of the above placement modules are contained in the Program's Field Placement Manual.[1] Refer to the sections on Student Responsibilities, Agency Responsibilities, College Responsibilities, and the corresponding evaluation forms provided in the field manual.

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[1] Sigetich, D. W. Field Manual: Mental Retardation Counsellor Program. Scarborough, Ontario: Centennial College, 1978.

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## Chapter 6

# TEACHING STYLES

Mary Ann Heverly, M.Ed. Project Associate,
Alternative Living Arrangement Training Project

## Introduction

Teaching style can refer to numerous aspects of teacher behavior. The manner in which a teacher interacts with students, the general principles embodied in a teacher's presentation of material and the specific format (i.e., method) used to present material may all be considered aspects of teaching style. Usually curricular models do not address the issue of how to teach; more often their primary focus is on the content of the course materials. Yet the form of one's teaching style is of the utmost importance, perhaps of more importance than the selection of materials. Even the teacher who is well prepared in terms of curricular materials, can develop bad teaching habits which negate the potential contribution of the curricular content to the student's development.

Maintaining sensitivity to how one is teaching is a most difficult task. Educational research has shown that most often teachers are unaware of their classroom behaviors. For example, teacher accounts of their classroom behavior are often contradicted by other observers (Good and Brophy, 1973). It is hoped that the presentation to follow will encourage instructors to become conscious of what they are doing when teaching and to seek feedback, not only from themselves, but also from their colleagues and students.

Addressing the issue of teaching style implies certain assumptions which not all educators would agree. For example, it makes little sense to spend time considering various aspects of teaching style unless some objective evaluation of different styles and methods can be made. Broudy (1972) has criticized attempts to construct operational definitions of specific behavioral outcomes in order to evaluate teachers because this approach does not tap the truly important outcomes of instruction, such as the tacit conceptual understanding which can be carried over into other areas of life. Broudy's position that teacher evaluation can be based on narrow outcome variables has some validity. This does not, however, warrant Broudy's position that operational definitions necessarily employ criteria with little utility and meaning. Students' understanding of material and their ability to apply what they have learned in a course can be set up as achievement criteria. To illustrate this point consider the steps a resident advisor should follow in conducting a task analysis, this skill can be demonstrated simply by requiring the student to recite these steps in sequence. However, the student's understanding of when a task analysis is necessary and the ability to effectively carry out a task analysis can be tested only by devising an appropriate assessment that requires him to operationalize his knowledge in a realistic "in vivo" situation.

It should also be kept in mind that student achievement in the cognitive domain should not be the only focus for educators. The interpersonal and affective experiences in the learning situation are also crucial, since they can positively or negatively affect student attitudes toward specific topics and learning in general. Feedback from students and colleagues can be of great value in sensitizing teachers to their interactions with students. There will always be instances in which there is some discrepancy in evaluations received from a group of individuals. However, the value of feedback lies in the patterns which emerge. If data from various domains of teacher interaction show the instructor as overly critical, or as being insensitive toward students, a wise instructor will give this feedback serious consideration. Thus, the more ecological the approach to evaluation is, the more useful will be the patterns which emerge. In sum, we are in agreement with Eble's (1977) position that it is difficult, but possible to evaluate teacher behavior and that good teaching is a skill which can be learned with appropriate feedback and practice

## Teacher Characteristics Associated with Student Motivation

A teacher who rules over students with an iron hand may insure that certain subject matter is learned or memorized, but the long term effects on student motivation are likely to be disastrous. Thus any analysis of teacher behavior must specify the outcome variables that are being used as criteria. In a recent review, Bowen and Madsen (1978) have described a style of teaching reported to enhance student motivation. They report that student's intrinsic interest in, as well as their enjoyment of a particular subject is increased by a teaching style which permits students to interact and to contribute their own ideas, opinions, and suggestions. Such teaching is often described as flexible, which means in part that the instructor is not bound to one method of presenting material, but can change methods to accomodate students' areas of interest, as well as their ideas and suggestions.

A finding which has emerged repeatedly (e.g., Bowen & Madsen, 1978) is that teacher enthusiasm and warmth are associated with student interest and student achievement. One of the problems with reports of such findings, as Bowen and Madsen (1978) have pointed out, is that adjectives such as "dynamic" and "enthusiastic" are rarely described in behavioral terms. As a result, it is not clear whether different researchers are describing the same phenomenon. This, however, does not mean that such definitions are impossible to achieve. Bowen and Madsen (1978) have suggested that the use of gestures, eye contact, and verbal inflections could be used to operationalize the constructs of teacher enthusiasm and warmth.

Another way to approach the measurement problem in defining teacher characteristics is to view it in terms of observers' general perceptions of the instructor. Many of the research studies leading to the conclusions just cited have been based on perceptions of the instructor. Thus, it may not be necessary to isolate specific "objective" behaviors which constitute teacher enthusiasm. However, what does seem to be crucial, is that observers agree in perceiving the instructor as warm, friendly, and genuinely interested in the subject matter. The importance of such perceptions was alluded to earlier; instructors are well advised to solicit feedback from a variety of observers. If the preponderance of opinion suggests deficiencies in one's teaching style, then the instructor should reconsider his or her manner of presentation.

Other helpful hints given by Good and Brophy (1973) include specific ways to effectively begin classes, how to give feedback that engages student participation, and how to ask questions which will stimulate thoughtful discussion. These are simple techniques which can greatly facilitate the major objective of teaching--learning.

## Methods of Presentation

Another important aspect of teaching style is the format in which material is presented. Although a great deal of effort has been put into research attempting to compare different methods of presentation, Davies (1973) has noted that one could conclude from this body of literature that there is little evidence that any one method is better than another. Nevertheless, Davies does not view this as cause for despair. He suggests that there are drawbacks to the criterion measures utilized, usually final examinations or final grades. Davies believes that there is evidence for the superiority of certain methods over others, if criterion measures are employed which tap higher level cognitive objectives and which also gather information on student attitudes and perceptions of the methods of presentation.

Perhaps the most traditional form of presentation is the lecture. Eble's (1977) initial advice concerning this method of teaching is: If you cannot lecture well, don't. Eble views the lecture as the most difficult format to do well. He goes on to provide a series of guidelines for evaluating and for improving upon one's style of lecturing. Foremost among these is his suggestion of shaping the lecture as much as possible into a modified format which permits some measure of spontaneity and student input. Nothing annoys students more than the lecturer who is obviously reading a presentation verbatim, with no allowance for adapting the topic to students' needs, interests, and level of understanding.

In spite of its great potential for boring students, the lecture does have advantages. For example, it is an extremely efficient means of covering material, especially as compared with the classroom discussion format, which requires more time in which to communicate the same information.

From another perspective, Broudy (1972) sees the lecture, which he refers to as the didactic approach, as the one teaching style which permits an objective evaluation of teacher performance. It is relatively easy to evaluate teachers who lecture because peers can judge the adequacy, accuracy, and quantity of information presented to a class in this fashion.

From the students' viewpoint, there is evidence that low ability students presented with lecture material are likely to perform better on both immediate and delayed recall of the information presented than they do when presented the same material in a discussion format (Davies, 1973). In addition, the lecture can be viewed as a format providing students with a great deal of structure, and it has been reported that students with high levels of anxiety do better with this kind of structured presentation (Berliner and Cahen, 1973).

In spite of the generally negative reviews given to the lecture method, the role of the teacher and the characteristics of the student population are factors that must be taken into consideration. Although they are rare, there are individuals who can deliver a lecture in a manner which maintains audience interest and attention. In addition, there are situations in which the audience or student population initially are favorably disposed to the lecture format and under such circumstances the lecture is likely to be a useful vehicle for communication (Davies, 1973).

There are a variety of teaching formats which are less structured than the traditional lecture approach. It should be stressed that the description "less structured" does not refer to a lack of organization and planning on the part of the instructor. Meticulous planning of the points to be covered and of the issues to be raised is required, and much thought should be given to the instructional techniques which will enable students to engage themselves in meaningful discussion of the issues.

Unstructured methods are unstructured in the sense that the instructor is flexible enough to incorporate spontaneous comments, ideas, and other student input in such a way that they are integrated into the issue at hand. This approach not only takes planning, but also practice in the classroom. However, when this format fails, it can be a devastating experience for the students who may emerge from the unstructured classroom confused and angry because they are not sure that they have learned anything.

Eble (1977) offers a list of specific suggestions for the classroom teacher who wants to increase his or her proficiency with the less structured format. Achieving such proficiency requires a delicate balancing act; it requires honestly listening to what students are saying and, almost simultaneously, thinking of ways to tie their thoughts and ideas to crucial aspects of a topic. Yet, successful implementation of this technique enables students to have an integrated view of a topic as well as increased interest and motivation.

Among the flexible methods which involve the students to a greater degree than the lecture format is the guided discovery method. Guided discovery may include small group or class discussion, and the lecture-demonstration. It may utilize such techniques as role playing, brainstorming or individual tutoring. Broudy (1972) uses the term "heuristic approach" to describe the discovery method and "philetic approach" to describe methods which emphasize the instructor's interpersonal relationships with students. Although Broudy (1972) views these styles with some concern viz-a-viz evaluating teacher's performance, more optimistic individuals (e.g., Davies, 1973) have begun developing a taxonomy of behaviors to catalog and fully describe approaches to teaching using the guided discovery method.

Although there is limited data on the guided discovery teaching format, some evidence exists which suggests that discussion results in better long term recall and understanding for high ability students (Davies, 1973). The less structured approach has been reported to be more effective for students who are high in need for achievement than for students who are low to moderate in need for achievement (Berliner and Cahen, 1973). However, it is important to note that there is conflicting information on the relative effectiveness of the lecture method compared to the discussion method. Some of the reasons for the current state of literature in this area are described later.

One of the chief advantages of class discussion is that it encourages student involvement in the learning process, and this involvement in turn may increase student motivation. Although discussion is not the most efficient way to impart information, it is particularly well suited to modifying attitudes and to influencing other aspects of affective behavior. Interpersonal skills are also more likely to be influenced by an approach which permits students to practice interacting with others (Davies, 1973).

## Selecting a Teaching Strategy

How does one select an appropriate teaching strategy? Davies (1973) approaches this question in terms of the goals an instructor wants to achieve in a class session. Cognitive objectives, especially lower level ones which tap basic knowledge and understanding of material, are well served by the more structured methods of lecture and programmed instruction. On the other hand, if affective objectives are the goal, most teaching methods can help students achieve lower level objectives, which require students to perform such activities as listening and responding to others. Davies (1973) perceives the less structured techniques to be more effective in achieving higher order affective objectives such as organizing a system of values.

Finally, student characteristics are important in choosing a teaching strategy. As was discussed, there is evidence that high ability students tend to perform better and to prefer less controlling methods of instruction, while less able students tend to do better with more structured teaching formats. If one assumes that students of lower ability levels tend to be more anxious, then it may be important to keep in mind Davies' finding that highly anxious students do better with the more controlling methods of instruction.

## A Note of Caution

The generalizations offered above concerning the choice of teaching style should be considered along with a warning against their indiscriminant application. Researchers attempting to find the "best" and most appropriate method of teaching soon learn that there is no single solution to this problem. Many of the findings in this area have not been supported by replication studies (Berlinger and Cahen, 1973). This is not surprising, especially if one stops to consider the innumerable factors that need to be taken into account. First, instructors differ in their enthusiasm for, and in their ability to use, different teaching styles. Second, the complexity of the content area or subject matter must be taken into account; what works well in an English literature course will not necessarily work in a behavior management course. Third, the specific objectives set for a course will affect the choice of teaching method; as noted earlier, objectives differ not only in type (i.e., cognitive or affective), but also in level of difficulty. Finally, individual student characteristics must be taken into consideration.

An entire area of research has been devoted to evaluating the relative effectiveness of teaching methods for specified groups of students. Thus far, the evidence on the relative effectiveness of teaching methods tends to vary from one study to another. Berliner and Cahen (1973) have suggested that this may simply indicate that a method's superiority may be restricted to a narrow age or grade level. Student populations can differ on a multitude of characteristics: age, sex, race, socioeconomic status, grade level, scholastic aptitude, anxiety, compulsivity, need for achievement, authoritarianism, creativity, cognitive style, need for affiliation, etc. Teachers may also differ on all of these characteristics, in addition to their characteristic teaching style. The resulting number of possible combinations of teacher-student characteristics that may exist within a particular class is astounding. Berliner and Cahen's (1973) review of educational research in this area suggests that an important variable may be the compatibility of teacher and students on one or more of these indices.

As was discussed, the instructor is not in the most advantageous position for evaluating his or her effectiveness in the classroom. Instructors must recognize students' and peers' perceptions, since they can be most useful in obtaining feedback on the effectiveness of one's teaching style. Instructors will accept feedback more readily if the persons providing feedback have been trained to perform this task in a nonjudgmental and nonthreatening manner. For example, Johnson (1972), has listed some basic rules to follow in providing feedback that can serve as constructive criticism. Such feedback can be used most effectively if the instructor is flexible and open to change--an ironic situation perhaps, since these are the very characteristics which have been most consistently linked with effective teaching.

## References

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The importance of the attributes just described often comes as a rude awakening to the novice instructor who may tend to focuse primarily on his or her mastery of the course material. Yet, as Eble (1977) has pointed out, one of the commonly held myths about teaching is "that teaching a subject matter requires only that one know it" (p. 10). Eble repeatedly stresses that the teacher's personality is not independent of one's teaching ability. Some instructors resent being asked to pay attention to their classroom style, since they feel they are being asked to act like "entertainers." Be that as it may, the boring presentation is much more common than is the theatrical presentation lacking substance. Bowen and Madsen (1978) have gone so far as to argue that style may be at least as important as competence, since students often assume that their instructors will be competent in terms of their knowledge of a subject.

Fortunately, there are sources describing specific ways in which teachers can improve their style of presenting material and their interpersonal relationships with students. The following section discusses some of the techniques which can help instructors achieve a good classroom environment.

## Techniques for Improving Style

There are a number of techniques which teachers can use to increase the students' attention, interest, and involvement in the classroom. As with any set of suggestions offered to instructors, the individual teacher will need to pick and choose, attempting to implement those which best suit his or her style. The indiscriminant application of techniques which an instructor does not feel comfortable with is a mistake. Rather, one must gradually develop new teaching styles at a pace which is comfortable for the individual.

One suggestion offered by Bowen and Madsen (1978) is to utilize the moderate novelty principle in presenting material. This simply involves presenting material that is slightly new - new enough so that students are not bored, yet not so unfamiliar that students become lost. Some instructors apply this principle by presenting a problem solving situation and eliciting class discussion on possible solutions. Another alternative is to give different problems to subgroups within the class, have them generate solutions, and then reconvene the entire class to discuss their solutions. For example, resident advisor (RA) trainees could be given specific examples of resident behavior which would impede community acceptance of residents; the trainees' task would be to describe how they would handle that situation.

Some instructors are comfortable with a more dramatic approach, such as taking a shocking or controversial position which is likely to outrage some students and elicit a lively discussion. For example, an instructor might introduce a session for RA trainees by presenting a strong position in favor of enforced sterilization of handicapped persons. Such ploys are most effective when there is a plan for eliciting specific points or arguments. The presentation should look spontaneous, but students will not be fooled if there is no plan to the session. It should be noted that this approach can backfire, especially when students are reluctant to defend or attack a potentially sensitive subject, or when the level of trust among students and between the instructor and students is low. Consequently, the instructor should have a variety of backup tactics at his or her disposal.

A related method of increasing student involvement is to have students role-play different sides of an issue. This permits the student to put distance between himself or herself, and an unpopular position, thus alleviating concern over being personally identified with an unpopular stance. Role playing could, for example, be helpful in discussing the recent trend toward deinstitutionalization of the developmentally disabled persons, since there may be no student in the class who will go against this trend and strongly advocate institutionalization. Moreover, role playing can be an effective way of changing attitudes on an issue (Davies, 1973), and may serve to build trust and group development among the students, as well as between the students and the instructor.

Eble (1977) advocates the use of personal anecdotes or illustrations as an excellent way of getting students' attention. Since most people respond positively to "real life" examples of a problem or issue, this technique can be highly effective. The instructor who is not afraid to exhibit a sense of humor, will develop an environment conducive to learning. This tactic works well when one is an accomplished joke-teller. However, as Eble (1977) has pointed out, most persons lack the professional comic's most important asset - a sense of timing. If this vital ingredient is lacking, the results are practically guaranteed to be disastrous. Anecdotes and illustrations _can_ be effective without the comic routine.

Rapport with students can be facilitated by following some basic rules which may seem obvious; yet, many instructors fail to use these simple devices, and the result can be rebellion and accusations of unfairness. First, the instructor's objectives and goals, both for the course as a whole, and for each class session, should be made _explicit_, with a rationale given for each objective, explaining to students why a given topic is important enough to be allotted class time. If there is no defensible reason for including a topic, the topic should be omitted. Preparing a rationale for each session is a particularly valuable exercise for the instructor just emerging from a program of graduate study, in which students are often socialized according to the principle that knowledge is a goal to be valued, regardless of its ultimate utility in an applied setting. Secondly, permitting students to provide input on some aspects of classroom functioning is a good way to increase students' feeling of involvement (Eble, 1977; Good and Brophy, 1973). For the instructor who feels strongly about his or her own guidelines concerning exams, papers, etc. students can still be brought into the decision making process on such issues as whether smoking is to be permitted in the classroom or whether review sessions are needed prior to each exam.

Good and Brophy (1973) have provided teachers with an excellent sourcebook of ideas. Although written primarily for elementary and secondary school teachers, most of their suggestions are applicable to any student population. For example, Good and Brophy describe the importance of considering the teacher as a modeling agent. An instructor who projects an attitude of enthusiasm and interest in a subject is modeling behaviors likely to be picked up by students. On the other hand, an instructor who appears bored or who apologizes for the need to cover specific material is sending the message that students are not expected to enjoy the classroom experience. In a similar manner, perceived teacher expectations concerning discipline, degree of interpersonal interaction and student participation, and other aspects of classroom functioning also affect student behavior.

## Chapter 7

# PROGRAM EVALUATION

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### Introduction

Since the public demand for accountability in educational endeavors is becoming stronger every year (Hayman & Napier, 1975), it is important that the intrinsic, programmatic benefits of evaluation be understood. Individuals are continually engaged in informal evaluation, not only with regard to tasks performed by themselves and by other persons, but also with respect to the performances of programs and institutions. The advantage that formal evaluation process has over informal evaluation is that it forces the criteria being used to be made public and explicit.

This chapter reviews some of the common misperceptions held about the evaluation process, distinguishes between traditional research design and evaluation designs, and describes that basic types of evaluation. The last two sections give examples of evaluation models and describe how an evaluation of the model curriculum for training ALA direct service personnel might be conducted.

### Misperceptions of Evaluation

The functions and purposes of evaluation are subject to a number of misunderstandings which can lead to skepticism or outright resistance on the part of participants in the program being evaluated (Van Maanen, 1979). Unfortunately, evaluation is often perceived in the same manner that the early "time and motion" studies of industrial psychologists were viewed by employees: as a threatening procedure. The general perspective leading to suspicion and distrust of the evaluation process is based on several a priori beliefs: (1) the evaluator is an outsider who has no sensitivity to the special conditions existing in a given setting; (2) the primary goal of the evaluator is to place a negative value on the current efforts of persons involved in the program being evaluated; (3) the evaluation is a short-term threat which must be endured only until the evaluator leaves and the process has been "completed."

The phrase "time and motion" study provides a clue to the resistance to evaluators in the industrial arena. Employees often feel that there is neither recognition nor appreciation of their status as persons with human rights and that they are viewed by evaluators as "automatons" whose individual motions are to be scrutinized and modified so as to minimize the time required to perform each component involved in carrying out their duties. Similar feelings are often aroused by the image of educational evaluators--the evaluator's need for specific operational outcomes to measure is often viewed as reflecting a mechanistic approach which disregards the "real" benefits of a program. Often what happens is that individuals endorse the general idea of evaluation, but balk at the prospect of having their own program targeted for evaluation.

The first reason cited above for resistance to the evaluation process referred to the perceived insensitivity of the outside evaluator. Although evaluation specialists disagree on the relative merits of the "in house" evaluator versus the externally based evaluator (Van Maanen, 1979), it is frequently the case that evaluation is conducted by someone within the organization. The advantage of such a procedure is that the "in-house" evaluator will usually have a better grasp of the organization's structure and function (both formal and informal) and goals (both explicit and implicit). Perhaps the most extreme example of an in-house evaluator is the classroom teacher who conducts evaluations to obtain feedback on whether or not his or her goals for student achievement are being attained (e.g., Davies, 1973). Aside from the traditional evaluation of how well course material has been mastered, the instructor may wish to conduct an evaluation of students' perceptions of the instructor's performance in communicating material and the appropriateness and relevance of the course itself (e.g., the instructional materials, the methods of presentation, the course requirements, grading procedures, etc.). While most teachers develop some sense of how much students are learning and how they feel about the classroom experience, an actual evaluation may bring to light unanticipated areas of difficulty. Of course, the gathering of such information does not terminate the evaluation process. When the instructor has learned which techniques and materials are not working in the classroom, attention can be given to reformulating these or discarding them in favor of new instructional methods and materials. When evaluation data are used in this way, evaluation can be viewed as a continual monitoring or "trouble-shooting" process.

An instructor's evaluation conducted for his or her own use can be criticized for lack of objectivity. In program evaluation, the potential lack of independence of the in-house evaluator has been used as an argument for having external evaluation. Nevertheless, in situations where an outside person is brought in to conduct an evaluation, it is of the utmost importance that the evaluator spend a considerable amount of time learning the formal and informal structure of the organization and its operation (Van Maanen, 1979). Failure to do so will simply confirm program participants' fears of evaluator insensitivity to the unique needs and goals of the program.

It is important to recognize that the outside evaluator should not arrive with a pre-established set of goals and objectives to be measured. The definition of goals and objectives must come in part from the persons working within the program (Van Maanen, 1979). Program personnel must work with the evaluation specialist to select and refine central program goals, and specify statements of these goals until precise objectives are constructed which are measurable and which adequately represent the goals deemed most crucial for the program's successful operation. This means, for example, that the same curriculum may be implemented at two different educational institutions but may require different evaluation instruments, especially if the program and objectives differ from one institution to another.

The second negative perception regard evaluation focused on the view of the evaluator as a person who is oriented toward finding out what is wrong with the program and punishing personnel whose performance is found to be deficient (Hayman and Napier, 1975). Ideally, the administrative or supervisory personnel who have commissioned the evaluation do not hold this view of the evaluator's function and do not plan to use the evaluation data to attack specific individuals, nor to support their biases for or against particular program components. If the evaluation is perceived as a constructive means toward strengthening the weaker aspects of the program, then it is possible for the process to be viewed as beneficial for persons at all levels within the program.

The third commonly held misperception is that evaluation is a procedure which is confined to a particular time period--that the evaluator comes in, evaluates, provides a report, leaves, and is never again seen. But for the evaluation to serve its primary function of strengthening the program, it must be perceived and utilized as a feedback mechanism; the results of the evaluation should be used to make changes in the program (Van Maanen, 1979). This requires follow up evaluation to determine if the changes are having the desired effect. Evaluation conducted in this manner is an ongoing monitoring process which serves to alert program personnel when the program is veering from its prescribed course.

Research versus Evaluation

Although "research and evaluation" are often considered in tandem, there are critical differences between traditional experimental research design and the methodology required for evaluation. For example, the true experimental design, complete with random assignment to groups, a manipulated independent variable and rigorous control of extraneous variables, is often not feasible for program evaluation, because of technical, ethical or pragmatic reasons. When applied to an evaluation setting, research methodology is employed to answer questions which are not necessarily best addressed by the traditional experimental design (Yavorsky, 1976). For example, the case study approach, often criticized as a design for research purposes, may be useful in an evaluation setting, where it can yield a great deal of useful information in studying new program areas (Van Maanen, 1979).

Another distinction between research and evaluation is that in traditional research design, the questions to be answered are derived from theory, while in evaluation, they are derived from the immediate needs of the program (Browder, Atkins and Kaya, 1973). Finally, cost-benefit analysis is a procedure which is integral to evaluation efforts, particularly in situations where programs with similar goals are being compared (Yavorsky, 1976). In "pure" research, cost-benefit analysis is not usually a concern.

Modes of Evaluation

A distinction is frequently made between two major types of evaluation, usually termed formative and summative. Formative evaluation is ongoing throughout the course of the program and provides immediate corrective feedback into the program. Formative evaluation might be thought of as a fine-tuning mechanism, since it can correct problems before the program has gone too far off course. Summative evaluation is conducted at the end of a program (or at the end of one program cycle) and is used to provide an overall assessment of the program's effectiveness (Van Maanen, 1979; Yavorsky, 1976). Summative evaluation can also provide feedback in that it can be used as the basis for modifications in the next cycle of the program.

Evaluation, whether formative or summative in nature, can be focused on different levels of the program's services: the clientele served, direct service staff, or administrative staff. In the educational setting, for example, the focus of study could be the students served, the teachers who provide direct service, or supervisory personnel. The appropriate level in any given situation depends on the questions being asked and on the criteria established to answer those questions.

Van Maanen (1979) has presented a general model of the evaluation process, one which outlines the steps involved and provides guidelines to follow at each stage of the process. For example, he describes how to work with program personnel to help them in formulating specific program goals, selecting those goals which require evaluation, and translating goals into behavioral statements.

A more specific model has been described by Kiresuk and Sherman (1968), the originators of goal attainment scaling, a procedure which can be used to evaluate individual client progress. Although Kiresuk and Sherman describe the model's application in the context of a community mental health program, the principles could be applied to a variety of settings.

Goal attainment scaling requires a committee of professionals who define one or more areas in which goals can be set for a client. For each area an ordered series of possible outcomes is constructed; these outcomes are ordered from the most unfavorable to the most favorable outcome thought possible. Each outcome is described in specific behavioral terms and values are assigned to each outcome, with a value of zero being assigned to the outcome judged most likely to occur. Increasingly favorable outcomes are given positive values and unfavorable outcomes are given negative values. This system is designed to produce a scale with a mean of zero and a standard deviation of one. Clients are randomly assigned to treatments and at the end of a specified period of time, the progress on each preassigned goal is evaluated and these scores are converted to T-scores by the application of a formula provided by Kiresuk and Sherman (1978).

Another example of a specific evaluation model, one which is primarily geared toward evaluation at the program level, is the Discrepancy Evaluation Model or DEM (Yavorsky, 1976). A major purpose of the DEM is to specify standards of performance for program components. Performance is then evaluated in terms of the degree of the discrepancy (either positive or negative) from the previously set standards. DEM is similar in process to goal attainment scaling; however, DEM is more explicitly directed toward evaluating program components, while goal attainment scaling focuses on evaluating the progress of individuals. The DEM Manual provides a guide for carrying out five stages of evaluation: design, input, process, and output evaluation, and cost-benefit analysis.

## Suggestions for Evaluating A Model Curriculum

Most evaluation models are general in nature and can be applied to a variety of settings, such as educational, medical, and industrial institutions and programs. Some concrete suggestions for evaluating a curricular model like the one presented in Chapter 5, may be of value to prospective users of this curriculum. Specifically, several targets of evaluation may be identified: 1) students' acquisition of knowledge, 2) their development of practicum-related skills, 3) student and faculty perceptions of the strengths and weaknesses of the curriculum, 4) longitudinal follow-up to assess the curriculum experience as a predictor of job performance and 5) satisfaction and tenure (Fiorelli, 1979).

Knowledge acquired by students can be assessed by pretest and posttest instruments administered for each course developed as part of the curriculum. Ideally, an appropriate control group would be available for purposes of comparison. A useful control group would consist of untrained persons (similar to model curriculum students) who are newly employed in a community living arrangement. If students do not demonstrate acquisition of knowledge and skills superior to that attained by persons whose only training is an equivalent amount of time spent on the job, then the value of the curriculum might be questioned. The pretests and posttests of knowledge acquired in the coursework should be developed after holding discussions with faculty to ascertain which topics will be covered in the courses and the breadth and depth of coverage planned for each topic. This can be accomplished by having faculty choose competencies (e.g., from the listing shown in Chapter 4) which are to be achieved by students; these competencies and their corresponding instructional objectives can serve as a guide in constructing the assessment measures. Moreover, pretest and posttest assessment of practicum-related skills can provide an index for assessing the practicum as a vehicle for developing on-the-job competencies. If possible, assessing skills at more frequent intervals would permit a more detailed analysis of the pattern of acquisition of those skills. Again, a control group of individuals who lack preservice training, but who have spent time on the job equivalent to the time put in by students could be most helpful in comparing the effectiveness of the curriculum to that of on-the-job experience.

Feedback from students, faculty and practicum supervisors on various aspects of the curriculum can serve as the basis for changing the curriculum to close gaps and to strengthen areas of coverage felt to be weak. Formative and summative instrumentation can be designed which taps both cognitive and affective education components. In either case, the results of these evaluations could serve as an important feedback mechanism by providing the basis for modifications to be made during the next program cycle. Another form of summative evaluation, follow-up of students who have completed the program, should examine job-related criteria of the curriculum's utility, viz., the proportion of students who obtain jobs in the field, the length of time they remain in the field, the degree of satisfaction with their preparation for the job, and the degree of satisfaction their supervisors have with their on-the-job performance.

Specific instruments for these different aspects of evaluation may have to be developed on the local level, so that the unique concerns and goals in each setting can be assessed adequately. This limits the generalizability of results from any given evaluation, but no alternative approach to evaluation will be feasible until a broadly based consensus is reached concerning appropriate competencies and criteria for assessing skills at different levels of expertise.

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## Chapter 8

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## APPENDIX A

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# APPENDIX B

## SAMPLE COMPETENCY MATRIX

| Number | Competency<br>HUMAN DEVELOPMENT COMPETENCIES<br>The resident advisor should be able to: | Is this competency one a student should be able to demonstrate during or at the end of training.<br>1 = definitely yes (high value)<br>2 = seems so (moderate value)<br>3 = no (little or no value) | Is this competency specific enough to communicate its main intent (the importance of the underlying skill).<br>1 = definitely yes<br>2 = seems so<br>3 = no | Is this competency specific enough to assist in generating instructional activities and guiding instruction<br>1 = definitely yes<br>2 = seems so<br>3 = no | Is this competency specific enough to assist in evaluating student and program progress.<br>1 = definitely yes<br>2 = seems so<br>3 = no | Is this competency<br>3 = too broad<br>2 = too specific<br>1 = just right<br>regarding specificity. |
|---|---|---|---|---|---|---|
| HDC 5 | Distinguish between the concepts of "critical period" and "sensitive" period" and explain the implications of these concepts for rehabilitative intervention | | | | | |
| HDC 6 | Define the terms classical conditioning and instrumental conditioning and distinguish between the two by giving an example of a classically conditioned response and an instrumentally conditioned response | | | | | |
| HDC 7 | Distinguish between positive reinforcement, negative reinforcement, punishment and extinction | | | | | |

# APPENDIX C

# RESIDENT ADVISOR TRAINING EVALUATION SYSTEM

# (R.A.T.E.S.)

# PRACTICUM COMPONENT

Developed by

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and

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## ACKNOWLEDGEMENT

We would like to thank Joe Fiorelli whose leadership in the ALA Curriculum Development Project helped make this system possible. Additionally, we would like to give credit to Dr. Terrence J. Piper who initially developed an observation form for teacher behavior and to Helene Lotman whose efforts in the modification of this original observation form are reflected in the present version of the Trainee Performance Observation System.

The Resident Advisor Training Evaluation System (RATES) is designed to provide a structured mechanism for providing feedback to Resident Advisors in training.

RATES consist of four forms that combine to provide evaluation of major components of practicum experience. These forms are as follows:

Weekly Trainee Time Form
Competency Evaluation Checklist
Practicum Project Guidelines
Trainee Performance Observation Form

The system is designed to actively involve an on-site field supervisor, a college/university supervisor, and the trainee in the evaluation process.

The Weekly Trainee Time Form (WTFF) is a convenient way for all parties to monitor trainee time at the placement site. On a daily basis the trainee signs his/her time in and out. This is verified by the field supervisor or his/her designee on a daily basis. At the end of the week, the trainee totals the hours for the week. This information is verified by the field supervisor and given to the college/university supervisor who monitors trainee attendance and time data in light of specific program requirements.

The Competency Evaluation Checklist (CEC) is a competency form which examines trainee status in four areas: (1) Professional Behavior; (2) Trainee Relationships with Residents and Staff; (3) Planning, Assessment, Diagnosis and Implementation; and (4) Communication and Coordination. The CEC is designed so it can be used by the field supervisor and for the college or university supervisor to identify trainee strengths and weaknesses. It can also be used for self-evaluation by the trainee. A copy of the CEC should be given to each trainee and field supervisor at the beginning of a practicum experience. Before the trainee is heavily invested in practicum, in terms of time and activities, the instructional and supervisory staff and the trainee should meet to formulate instructional objectives for those competencies deemed of immediate importance. At least one third of the way through the practicum experience the trainee, field supervisor, and college supervisor should independently evaluate the trainee's development on the competencies assessed by the CEC and again near the end of the practicum experience. A meeting should be arranged to share the practicum experience. A meeting should be arranged to share the ratings, discuss the trainee's specific strengths and weaknesses, jointly target trainee behaviors for change, and develop needed learning activities. It may be useful to add additional competencies in a similar format for specialized RA skill development, not covered in the generically oriented CEC (e.g., working with severely disturbed or medically involved populations). It may be necessary to designate an order in which the competencies will be considered. This may take the form of first practicum or second practicum competencies and is dependent upon the type of placement, setting, practicum length, and other idiosyncratic factors.

The Practicum Project Guidelines detail possible activities trainees can carry out to enrich the practicum experience. These should be assigned and evaluated by the college/university supervisor. While all of the projects are potentially valuable experiences, the number required vary depending on student needs, readiness, and practicum length. Again it may be useful to order the activities and designate some of the projects as first or second semester practicum requirements.

The Trainee Performance Observation Form (TPOF), a modification of similar teacher observation systems (Piper and Elgart, 1979; Lotman, 1977; Lotman, Meddock, Piper and Boyd, 1976), is designed to be used for direct observation of resident/trainee interaction. The TPOF provides a format to monitor specific trainee behaviors that are felt to be critical to developing, decreasing, and/or maintaining certain resident behaviors. These behaviors include trainee responses to residents' social behaviors, planned or unplanned, and trainee responses in informal and formal instructional activities.

R.A.T.E.S.

## WEEKLY TRAINEE TIME FORM

TRAINEE ______________________________

FIELD SUPERVISOR ______________________________

COLLEGE SUPERVISOR ______________________________

PLACEMENT SITE ______________________________

WEEK OF __/__/__ TO __/__/__

| | Time In | Time Out | No. of Hours Per Day | F/S* Verification |
|---|---|---|---|---|
| SUNDAY | | | | |
| MONDAY | | | | |
| TUESDAY | | | | |
| WEDNESDAY | | | | |
| THURSDAY | | | | |
| FRIDAY | | | | |
| SATURDAY | | | | |

TOTAL HOURS PER WEEK: ________

*Field Supervisors Verification - Initial daily and sign at end of the week.

# R.A.T.E.S.
(Prototype Edition)
# COMPETENCY EVALUATION CHECKLIST*

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Department of Special Education
Temple University

Howard Margolis, Ed.D.
Developmental Disabilities Center
Temple University

Trainee's Name ______________________________

Date of Evaluation ______________________________

Community Living Arrangement Site ______________________________

Field Supervisor ______________________________

College or University Supervisor ______________________________

Trainee's Signature ______________________________
(To be signed after the trainee and supervisor have jointly reviewed the evaluation)

**KEY**

N.D. = Not Developed

P.D. = Partially Developed

F.D. = Fully Developed

N.A. = Not Applicable

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*It is recommended that instructional and supervisory staff, together with the trainee, transform each of the competencies into instructional objectives containing a statement of performance, criteria, and conditions. At the very minimum, priority competencies should be formulated into instructional objectives.

PROFESSIONAL BEHAVIOR

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 1. The trainee arrives promptly for scheduled practicum experiences. | | | | | |
| 2. The trainee follows the direction of resident staff. | | | | | |
| 3. The trainee is receptive to constructive feedback as displayed by changes in behavior. | | | | | |
| 4. The trainee displays initiative by defining and solving problems, introducing new ideas, assisting in emergency situations, and seeking out resources and/or materials. | | | | | |
| 5. The trainee fosters the exchange of information through asking questions and sharing information. | | | | | |

PROFESSIONAL BEHAVIOR

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 6. The trainee's interactions with residents reflects concern and respect. Demonstration includes: | | | | | |
| a. making positive comments for positive behaviors | | | | | |
| b. using a language level commensurate with the residents' ability to respond | | | | | |
| c. physically attending as described by Egan's SOLER (1975) concept:<br>S = faces the other person SQUARELY<br>O = adopts an OPEN posture<br>L = LEANS toward the other person<br>E = keeps good EYE contact<br>R = tries to be "at home" or relatively RELAXED in this position | | | | | |
| d. fostering independent functioning | | | | | |

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Egan, Gerard. Exercises in Helping Skills: A Training Manual to Accompany The Skilled Helper. Montery, California: Brooks/Cole Publishing Company, 1975.

## PROFESSIONAL BEHAVIOR

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| e. not shouting at or denigrating residents | | | | | |
| f. implementing other agreed upon indices | | | | | |
| 7. Other ____________________<br>______________________<br>______________________ | | | | | |

## RELATIONSHIPS WITH RESIDENTS AND STAFF

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 8. The trainee interacts effectively as a problem solver rather than a problem creator. | | | | | |
| 9. The trainee uses the principles of group dynamics as described by Johnson and Johnson (1975) and/or other recognized authorities to successfully contribute to the resolution of interpersonal problems present at the practicum site. | | | | | |

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Johnson, David W., and Johnson, Frank P. *Joining Together: Group Theory and Group Skills*, Englewood Cliffs, New Jersey: Prentice-Hall, 1975.

## RELATIONSHIPS WITH RESIDENTS AND STAFF

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 10. The trainee facilitates informal social interaction between the staff, the residents and the community. | | | | | |
| 11. Other ________________<br>________________________<br>________________________ | | | | | |

## PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 12. The trainee follows the guidelines of the resident's Individual Program Plan (IPP). | | | | | |
| 13. The Trainee appropriately administers assessment instruments to determine the levels of resident functioning in the following areas:<br>Activities of Daily Living<br>Social Behavior<br>Cognitive Behavior<br>Motor Behavior | | | | | |

| | PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION | | | | |
|---|---|---|---|---|---|
| | N.D. | P.D. | F.D. | N.A. | Comments |
| 14. The trainee formulates a comprehensible set of instructional objectives for a resident displaying learning or behavioral difficulties. These objectives conform to Mager's (1975) formulations for performance criteria, and conditions. | | | | | |
| 15. The trainee provides the necessary amount of structure, organization and explanation for a resident to successfully make a new, planned response. | | | | | |
| 16. The trainee effectively organizes (analyses, synthesizes, evaluates) data for formulating and implementing instructional strategies. | | | | | |

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Mager, Robert F. Preparing Instructional Objectives, 2nd edition. Belmont, California: Fearon Publishers, Inc., 1975.

PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 17. The trainee selects appropriate reinforcers and reinforcement schedules for residents which are consistent with the objectives of instruction or therapy. | | | | | |
| 18. The trainee presents new tasks to residents in such a manner that they are able to successfully accomplish the tasks without exhibiting frustration, e.g., errorless learning procedures. | | | | | |
| 19. The trainee applies the principles of task analysis when teaching new skills to residents. | | | | | |
| 20. The trainee designs a behavior change plan for residents warranting such attention, gains program planning team approval for implementing the plan, and implements it, under supervision. | | | | | |

|  | PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION |  |  |  |  |
|---|---|---|---|---|---|
|  | N.D. | P.D. | F.D. | N.A. | Comment |
| 21. The trainee observes and records resident behavior systematically and accurately, so that it is clear whether or not a resident is meeting his instructional objectives or exhibiting a suspected problem. |  |  |  |  |  |
| 22. The trainee modifies programs he is directing based on records of resident behavior and provides theoretical and/or data-based support for modifications. |  |  |  |  |  |
| 23. The trainee makes professionals, residents, and other significant individuals aware of resident needs, instructional objectives, program content and progress, so that, commensurate with their ability to express themselves, those involved individuals paraphrase the information, ask relevant questions, and describe what they can do to enhance the success of the program. |  |  |  |  |  |

PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 24. The trainee maintains all records and reports required by the practicum site. | | | | | |
| 25. Under supervision, the trainee distributes medication in a manner consistent with agency policy. | | | | | |
| 26. The trainee assists residents in meal planning and preparation in a manner consistent with nutritional and sanitary principles for well-being. | | | | | |
| 27. The trainee assists residents in making pleasurable use of their leisure time. | | | | | |
| 28. The trainee delineates those resources needed by residents for meeting their program objectives and, under supervision, directs residents and their families to those resources which are available in the community within which they live. | | | | | |

PLANNING, ASSESSMENT, DIAGNOSIS AND IMPLEMENTATION

|  | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 29. Other ____________________<br>____________________<br>____________________ |  |  |  |  |  |

COMMUNICATION AND COORDINATION

|  | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 30. The trainee consults and coordinates efforts with others both inside and outside of the CLA. |  |  |  |  |  |
| 31. The trainee communicates program strategies to residents, parents and relevant professionals in a manner that elicits cooperation. |  |  |  |  |  |
| 32. The trainee uses appropriate terminology to enhance rather than confuse communication and to clearly articulate client levels of achievement, deviances and needs. |  |  |  |  |  |

## COMMUNICATION AND COORDINATION

| | N.D. | P.D. | F.D. | N.A. | Comments |
|---|---|---|---|---|---|
| 33. The trainee discusses program parameters, giving a clear rationale for the program and its elements, including client goals and program activities. | | | | | |
| 34. The trainee gives information and feedback that is descriptive, refers to a standard (e.g., "You did exactly what was agreed to. John was able to stack the dishes without breaking any.") and is devoid of personally-oriented, value-laden terms (e.g., "That's a poor job. It doesn't show much thought on your part.") | | | | | |
| 35. Other ______________________<br>______________________________<br>______________________________ | | | | | |

## R.A.T.E.S.

## PRACTICUM PROJECT GUIDELINES

Specific assignments, formats and evaluation of projects will be conducted by the college/university supervisor.

1. Develop an appropriate individual program plan for a resident based on available diagnostic data which includes behavioral objectives, staff responsibilities for components of the IPP, and methods and materials where appropriate.

2. Given CLA resident in the practicum setting, assess and then develop a plan to improve the following social skills:

    a. manners and etiquette
    b. respect for rights and property of others
    c. making and keeping appointments
    d. recognizing offensive behavior in self and others
    e. the art of conversation
    f. personal space
    g. authority and intimacy in relationships in the ALA, workshop, job, school and community

3. Task analyze a series of activities required of a resident using the framework of a prominent task analysis procedure.

4. Develop a case study of an individual exhibiting severe behavior and/or learning problems which clearly, specifically and operationally delineates:

    a. the nature of the problem(s)
    b. probable causation
    c. suggested solutions
    d. results of treatment
    e. recommendations for the future

5. Given specific data, write an individual habilitation plan for re-integrating a client into the community.

6. Given a particular set of data, detail, in a step-by-step fashion, how a particular specified problem solving procedure can be used to identify and resolve a problem.

7. Describe the purpose, content, use and/or reporting procedures of the following documents:

    a. the individual program plan
    b. life management plan
    c. intake and proposed service plan
    d. CLA provider personnel policies and procedures manual
    e. county-provider contract
    f. CLA program provider agency monthly population report
    g. CLA implementation procedure worksheet

   h. vacancy reports
   i. incident/death report
   j. fire report
   k. county and regional CLA checklists or required infile documentation

8. Develop a plan for formulating house rules which:

   a. involves CLA residents
   b. is consistent with the concepts of normalization and dignity of risk
   c. is stated in behavioral terms

9. Design a plan for housekeeping tasks which:

   a. integrates IPP goals of residents
   b. shows a rotation of everyday home maintenance tasks (e.g., cleaning, laundering, etc.)

10. Given the requisite data:

    Write a sample menu plan which includes three nutritionally balanced meals per day over a one-week period that (a) utilizes the four basic food groups, (b) shows variety and is appealing, (c) demonstrates economy by using comparative shopping techniques and store coupons, (d) is within a given food budget, and (e) is supported by a detailed shopping list.

11. Given ALA budget data, develop a model petty cash account and a plan for its implementation which includes CLA residents appropriately and is consistent with practicum agency and fiscal guidelines.

# Directions for Use of the
# Trainee Performance Observation Form (TPOF)

The TPOF is designed to be used for a structured 10-minute observation of trainee/resident(s) interactions.

Each category has spaces for recording the frequency of trainee behaviors in 30-second segments. Trainee responses which are focused upon include antecedent and consequent trainee responses to elicit and/or consequate resident social and "academic" (or instructional) behavior. The specific categories addressed by the form and their definitions follow.

## TRAINEE RESPONSES TO RESIDENTS' SOCIAL BEHAVIOR

### Trainee Attention to Pro-social Behavior

Planned Positive - The trainee provides planned verbal comments and/or physical contact for appropriate social behavior. Planned refers to the situation in which a decision was made about how staff should react to the resident's social behavior prior to the interaction. This is the case where a program is developed to attempt to increase specific social behaviors (e.g., saying "Hi," asking questions, sitting or standing appropriately, maintaining eye contact, etc.) by staff reacting to the behavior in a consistent way. Typically, trainee attention would be verbal praise often combined with physical contact (e.g., "I like the way you did that!" "That's great!" "You're really trying!" "I like the way you're eating!"). In some setting and/or programs primary or token reinforcement procedures may be paired with the verbal praise.

Positive - This category is almost identical to the Planned Positive category. It differs from the Planned Positive category in that it refers to non-planned positive attention to a resident's social behaviors.

### Trainee Attention to Un-social Behavior

Planned Negative - The trainee provides planned verbal comments and/or other consequences for inappropriate social behavior. Planned refers to the situation in which a decision had been previously reached regarding the manner in which staff should react to specific inappropriate social behaviors prior to the interaction. This is the case where a program is developed in an attempt to decrease specific inappropriate social behaviors (e.g., hitting, kicking, throwing, swearing, public masturbation, verbal outbursts, self-stimulation, etc.) by staff reacting to the behavior in a consistent fashion. Negative attention may be verbal ("Stop that!" "Do not . . .) or physical as in an overcorrection procedure or a combination of the two ("Do not scream" coupled with the resident being taken for a time-out).

Negative - A negative is almost identical to a planned negative. However, it refers to a negative which is not planned prior to the situation.

Trainee Neutral Verbal Guidance and/or Feedback to Residents

This category refers to a trainee's verbal responses that give instructions or neutral feedback to the resident. Example would include statements such as "Please hang up your coat," "We'll talk about that later," "Sit down," "The job's done."

TRAINEE RESPONSES IN INFORMAL OR FORMAL INSTRUCTION ACTIVITIES

This section of the form is used to record trainee responses in formal or informal teaching situations. It is assumed that typically the trainee is attempting to develop specific resident skills in activities of daily living, cognitive, motor, or self-help areas.

Positive - This category refers to positive verbal statements made by the trainee to reinforce specific correct resident responses in an instructional setting. Trainee statements may be paired with physical contact and/or token or primary reinforcement. Some examples are as follows: "Good! That's right!" "Great, you're correct!" "You're doing a fine job!"

Neutral - Neutral attention refers to instructions, directions, or the neutral verbal statements directed to a resident. Examples would include statements such as "Look here," "Put the spoon on the other side."

Negative or Inappropriate - Negative or inappropriate attention refers to disparaging negative verbal statements directed to residents after an incorrect response. Examples would be as follows: "[shouting] No! That's wrong!" "Boy, that's a dumb answer!" "You can do much better if you wanted to." This is different from "No, that's not it, try another way," which would be scored as a "corrective" response. Correctives are differentiated from negatives by tone of voice, intensity, the opportunity to respond again and the disparaging, disrespective quality of the remark.

Corrective - A corrective is verbal statement in which the trainee tells the student that his answer is incomplete or wrong and provides the student with additional input so a correct response is possible. The trainee then models the correct response or changes the stimulus conditions in some manner and gives the resident the opportunity to respond again. Examples would include the following: "No, that's wrong, the fork goes here. Point to where the fork goes." "Nice try, but not quite right." "Watch me, the timer goes on this way . . . You try it again."

## Observer Use

Prior to observation, the observer should be familiar with planned programs designed to increase, decrease, or maintain a resident's specific behaviors. During the 10-minute observation, the observer records the frequency of trainee responses as they occur. Each vertical column comprises a minute. Tallies are made in the 30-second segment in which the response occurs. It should be noted that all categories of the form may not be relevant during a particular observation. However, the effect of this is minimized when repeated observations are conducted during different times and activities.

Observers should freely write comments on the observation form and at the conclusion of the observation. In addition, observers should provide relatively immediate feedback to the trainee. Areas of importance would include comparisons of positive to negative interactions. From the data the trainee should be allowed to conclude if he is primary positive, primary negative, or neutral. Additionally, one might wish to give feedback on, and provide examples of, the quality (tone, enthusiasm, etc.) of positive comments. These can be monitored by the observer circling poor quality positives when they are tallied. In instructional activities, the positive/negative ratio would be an important area in which to give feedback as would the appropriate use of corrective techniques.

While it is unlikely that any observer can code all of the relevant behaviors that make an excellent Resident Advisor, the TPOF attempts to monitor, in a systematic fashion, RA behaviors which are most critical for positive resident change and growth.

### References

Egan, Gerard. Exercises in Helping Skills: A Training Manual to Accompany The Skilled Helper. Montery, California: Brooks/Cole Publishing Company, 1975.

Johnson, David W., and Johnson, Frank P. Joining Together: Group Therapy and Group Skills, Englewood Cliffs, New Jersey: Prentice-Hall, 1975.

Lotman, H. A. Behavioral orientation to teacher training. Paper presented at AAMD Region IX, Baltimore, Maryland, 1977.

Lotman, H., Meddock, T. Piper, T., Boyd, L. A. A model for systematic self evaluation and supervision feedback to increase competencies of teachers for the severely and profoundly impaired. Paper presented at Regional Convention of the American Association on Mental Deficiency, Williamsburg, Virginia, 1976.

Mager, Robert F. Preparing Instructional Objectives, 2nd edition. Belmont, California: Fearon Publishers, Inc., 1975.

Piper, T. and Elgart, D. B. Teacher Supervision through Behavioral Objectives. Baltimore, Maryland: Paul H. Brookes, 1979.

## RATES
## TRAINEE PERFORMANCE OBSERVATION FORM

TRAINEE ____________________ OBSERVER ____________________

DATE ____________________

OBSERVATION TIME - FROM __________ TO __________

SETTING ______________________________

### TRAINEE RESPONSES TO RESIDENTS SOCIAL BEHAVIOR

Trainee Attention to Pro-social Behavior

PLANNED POSITIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

POSITIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

Trainee Attention to Unsocial Behavior

PLANNED NEGATIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

NEGATIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

### TRAINEES NEUTRAL VERBAL GUIDANCE/ FEEDBACK TO RESIDENTS

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

### TRAINEE RESPONSES IN INFORMAL/FORMAL INSTRUCTIONAL ACTIVITIES

Attention to Correct/Incorrect Resident Responses

POSITIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

NEUTRAL

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

NEGATIVE OR INAPPROPRIATE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

CORRECTIVE

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |

COMMENTS:

# APPENDIX D

## Sample Protocol for College-Based ALA Training Program

John P. Mannino, Ph.D.
Associate Professor of Special Education
Life Management Services for the Handicapped
Bachelor of Science

Department of Special Education
Edinboro State College
Edinboro, PA 16444

PLANNING COMMISSION

DOCUMENT TWO:

APPLICATION FOR APPROVAL FOR PROGRAM DEVELOPMENT

TITLE AND HEGIS CODE NUMBER OF PROGRAM: 2104

BACHELOR OF SCIENCE: LIFE MANAGEMENT SERVICES FOR THE HANDICAPPED

STARTING DATE:

FALL, 1978

CONTACT PERSON:

JOHN P. MANNINO

My approval of the attached program application carries with it my intent to seek approval for budget and space should the program be approved by the college.

APPROVED:

| | |
|---|---|
| School Dean | Date |
| Dean of the School of Graduate Studies<br>(Graduate Program Only) | Date |

The School Priority Order Listing for all programs not yet approved for implementation as of ______________ (date) is as follows:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

## I. OBJECTIVES AND CURRICULUM

A. What are the major objectives for the proposed program?

The objective of the program is to educate and prepare undergraduate students to provide comprehensive habilitative services to handicapped children and adults (mentally retarded, physically impaired and/or emotionally disturbed) who are institutionalized or who have been released to community-based residential programs. It is this latter effort that principally concerns this program. The present trend towards the "least restricted environment" as mandated by federal and state laws, is a serious challenge to the century-old practice of institutional or custodial care of the handicapped. This practice has been looked upon as dehumanizing since such facilities tend to have violated the constitutional rights of the handicapped by denying his/her right: to dignity, to the opportunity to achieve the greatest measure of independence; to liberty and the pursuit of happiness. The purpose therefore of community-based residential services is to provide ongoing developmental experiences which may not be available at home, in schools or in the institution. These experiences are continuous throughout their lifetime and depending on the nature of the handicapping condition, may require structured living and learning situations.

The impetus for change has been much greater in recent months than has been the availability of specially trained personnel. This relatively new concept of community residential services has demonstrated the need for individuals who possess a wide range of competencies related to this new area of human services. The new program in Life Management reflects those competencies. In general, the life management specialist will be prepared to facilitate the adjustment process of deinstitutionalization by providing effective community living experiences as well as leadership in the development of programs and habilitative services for the handicapped.

B. Curriculum. How does the curriculum relate to the objectives identified in (a) above? What course or experience does the college now offer and which courses or experiences are needed to meet program objectives? Identify courses/experiences currently offered with a "C," and those needed with an "N."

The course contents have been reviewed and the composition of the program provides areas of specialization which generally include nature and needs, intervention and treatment and a list of supportive courses.

Initially, one new course will need to be written. The Areas of Specialization provide courses that have flexibility so as to meet individual student needs and to develop those competencies in direct service. Practicum experiences are readily available within short distances of the campus and provide varied community-based residential programs for field assignments.

## BACHELOR OF SCIENCE: LIFE MANAGEMENT SERVICES FOR THE HANDICAPPED

## DEPARTMENT OF SPECIAL EDUCATION

## EDINBORO STATE COLLEGE

| | | | Credits | |
|---|---|---|---|---|
| I. | General Education | | | 60 |
| II. | Areas of Concentration | | | 48 |
| A. | Nature and Need | | 15 | |
| C - EX215 | Psychology of Exceptional Children | 3 | | |
| C - EX241 | Psychology of Mentally Retarded<br>or | 3 | | |
| C - EX471 | Psychology of Physically Handicapped | | | |
| C - HP537 | Health Problems of the Handicapped | 3 | | |
| C - PS265 | Psychology of Adjustment* | 3 | | |
| C - SO305 | Urban Sociology* | 3 | | |
| B. | Treatment and Intervention | | 27 | |
| C - EX309 | Principles of Behavior Management | 3 | | |
| N - EX325 | Developmental Strategies in Habilitation | 3 | | |
| C - EX301 | Principles of Assessment and Prescription | 3 | | |
| C - EX394 | Field Practicum with Mentally Retarded | 6 | | |
| C - EX392 | Field Practicum with Physically Handicapped | 6 | | |
| N - EX595 | Field Practicum in Management | 6 | | |
| C. | Electives in Major | | 6 | |
| III. | Required Supporting Areas | | | 12 |
| | Twelve (12) semester hours of courses listed in Part V of which six may include General Education, area C. | | | |
| IV. | Electives | | | 8 |

*Prerequisites PS101 and SO200 can be used for partial fulfillment of General Education Elective requirements.

V. Other courses that would be appropriate for the program:

A. Human Growth and Development

| | |
|---|---|
| PS101 | General Psychology |
| PS227 | Experimental Psychology |
| PS317 | Child Psychology |
| PS390 | Social Psychology |
| PS400 | Human Learning |
| PS315 | Psychology of Adolescence |
| SH202 | Introduction to Speech Therapy |
| PS370 | Psychology of Personality |
| PS375 | Introduction of Psychology Assessment |
| EX533 | Speech and Language Problems |
| HI328 | History of Medicine |

B. Administrative Processes

| | |
|---|---|
| PO200 | Introduction to Government |
| PO215 | American State and Local Governments |
| PO306 | Public Administration |
| PO508 | Governmental Budgeting and Finance |
| PS470 | Industrial Psychology |
| MA209 | Mathematics of Finance |
| PO511 | Public Personnel Administration |
| EC100 | Elements of Economics |
| EC105 | Consumer Economics |

C. Social Processes

| | |
|---|---|
| SW300 | Social Welfare as a Social Institution |
| SW401 | Introduction to Social Work Methods |
| SO207 | Contemporary Social Problems |
| SO305 | Urban Sociology |
| SO335 | Juvenile Delinquency |
| SO340 | Sociology of Marriage and the Family |
| AN280 | Introduction to Anthropology |
| SO200 | Principles of Sociology |
| SO366 | Social Change |
| AN220 | Culture and Personality |
| HI397.62 | History of Institutions |

D. Health, Physical Development and Leisure Time

| | |
|---|---|
| HP130 | Personal Hygiene |
| HP210 | Applied Human Anatomy in Health and Physical Education |
| HP562 | Physical Education and Recreation for the Exceptional Child |
| HP442 | Principles of Recreation |
| HP110 | Health and Physical Conditioning |
| AE319 | Arts and Crafts for Special Education |
| ME507 | Music for Exceptional Children |
| HI398.56 | History of Sports |

E. Other Related Courses with Approval by Advisor

## II. NEED, ENROLLMENT AND EMPLOYMENT OPPORTUNITIES

### A. Statement of need for the program

The United States Senate, HB 1649, (proposed and to be adopted within the next few months) related to specific directives with respect to habilitative services. The concept of living in least restricted environment is a predominant feature of the proposal. The Commonwealth of Pennsylvania, however, has provided funding for about a fifth of our institutionalized persons to be placed into community-based residential programs. These were initiated approximately five years ago. Since then, 2,200 persons have been returned to their home communities. The full quota of eligible clients has not been achieved and the funds are remaining idle. Several factors have been alluded to, one being a lack of specially trained personnel and another being community attitudes. Hiring practices have been left to local agencies using their best judgments; therefore, the staff reflects a wide range of professional preparation but none specifically trained in life management services. Clarion State College presently is the only college in the Commonwealth and one of a few in the nation that prepares students in life management.

Based on the population already being serviced (2,200), and using a six to one (client-staff) ratio, approximately 360 life management specialists would be employed if colleges have life management programs in existence. Approximately 100 are needed now to fulfill the initial funding to permit handicapped persons to return to their home communities. (Documents supporting the funding are available through the Department of Welfare.)

The need for life management specialists is reflected not only in this state, but throughout the United States. The contact person of this new college program has co-authored materials relating to developmental-habilitative services and has been adopted by agencies in approximately 35 states. This also suggests a need for professionally trained personnel as well as the national growth of community-based programs.

The social implications in some areas of this state and other states have been very critical. A grave reluctance to have handicapped persons live in the community has been voiced creating suspicion and even open hostility toward them. It is believed that citizens would be more receptive to their handicapped neighbors if they were able to recognize the training, competence and expertise of the life management specialist and that the concept of community-based programs is not a whim but a critical social need for the handicapped and acknowledged by institutions of higher learning.

The National Association for Retarded Citizens (N.A.R.C.) which is composed chiefly of parents of the handicapped represents probably the most influential lobby in federal and state government. That membership is and has been a driving force towards achieving legislation that now provides equal opportunities in education through mainstreaming and in more normalized living experience through life support systems within the community rather than the institution.

The Pennsylvania Association for Retarded Citizens (P.A.R.C.) has adopted a five-year action plan for personnel development for community programs. The document clearly relates to "training professionals in the behavioral sciences and the helping professions, to provide their students opportunities to carry on field work jointly, thus creating and developing an interdisciplinary training experience in working with the intellectually handicapped."

Letters of support and interest are available upon request. These letters come from agency directors, from parent groups and individual professionals directly related to community residential programs. Their concerns are well stressed with respect to the need to initiate this new program at Edinboro State College.

Community-based residential services for the handicapped is an international movement, having been initiated in Sweden about 15 years ago. It is known that neighboring Canada is well advanced in the concept of community residential programs and are also experiencing a lack of specially and professionally trained personnel. Within the past several years national and state professional organizations such as C.E.C. (Council for Exceptional Children) and A.A.M.D. (American Association for Mental Deficiency) have featured in their conferences noted authorities on this new concept of community-based residential programs. The emphasis on that topic has been steadily increasing over the years.

Although the focus in this statement of need involves the retarded person, it must be noted that other handicapping conditions may eventually be included in this program. The greatest concern at this point in time is the retarded population and the present mandates. This program is an effort to meet their need. Other handicapping conditions receiving similar considerations include the socially and emotionally disturbed (juvenile delinquents) and the physically incapacitated. With respect to the emotionally disturbed, alternate programs in the community have been established in lieu of tight security and institutional placement. The Governor's Justice Commission and the juvenile court system are encouraging community-based treatment centers in group home facilities. Harbor Creek School for Boys operates several such facilities. The life management specialist would be very well suited to perform in those programs and settings. The plight of the physically handicapped is recognized at Edinboro. These people are generally left to private enterprise and individuals to provide supportive services for them in the community. They are well provided for at home while parents are living but generally experience much hardship when by themselves. Scattered, private efforts to provide group home facilities for the physically handicapped have been noted. A concern that has been evidenced is the exploitation of the handicapped, physically and mentally. It is believed that they are deserving of the concern, the support and the protection of a life management specialist.

It is important to note that the program as it expands will provide other areas of emphasis to include the emotionally disturbed and the physically handicapped.

B. Number of students to be enrolled in the program

| | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|
| New Enrollment | 20 | 20 | 20 | 20 |
| Transfers for Special Ed. | | 4 | 4 | 4 |
| Attrition | | 4 | 4 | 4 |
| Accumulated Enrollment | 20 | 40 | 60 | 80 |

C. Student Enrollment Potential

Initially it may be expected that many students in teacher education (Special Education) may choose to prepare for life management services in lieu of teaching. A significant drop in teacher education may encourage alternatives in the service of the handicapped other than teaching. Other students in the program may be referred by community agencies mainly in the northwestern region of the Commonwealth and where community-based residential programs are predominant. A significant increase in the enrollment is anticipated after the program has been initiated.

Parents and guardians of the handicapped will expect the local agencies to staff and to complement community residential programs with skilled, competent and specially trained professionals. Their influence will be more prevalent in the community than they were able to exercise while the handicapped were in state institutions.

D. Employment Opportunities for Program Graduates

The life management specialist may be employed by a public or private agency that provides community residential services such as group homes, apartments and transitional facilities. The life management specialist may also be employed by public or private institutions such as Polk, Selingsgrove, Laurelton State Schools and others. Other facilities may include: day care centers, sheltered workshops, related mental health agencies, schools and hospitals.

An outline of specific duties is provided below:

1. Specialist may live in (co-habitation) group home with six to eight clients and act as group home manager with the following responsibilities:
    a. general home maintenance
    b. supervision of clients
    c. direct service: training of clients:
        1) individual goal planning techniques
        2) treatment intervention and strategies emphasizing self-helf skills, personal management, communication home management, social awareness counseling, career planning, community
        3) utilization of recommended programming and assessment instruments such as Developmental Assessment of Life Experiences, Program Assessment Chart, Adaptive Behavior Scale and others

   4) Conforming to standards outlined by Program Analysis of Service Systems
  d. involvement with other community agencies
   1) schools (education)
   2) hospitals (medical and mental)
   3) mental health
   4) employment agencies (sheltered or other competitive community employment)
   5) public relations

2. Specialist may be employed by public or private agencies conducting day care activities, sheltered workshops or day programs in continuing education. (Note: Generally involve pre-institutional cases.) Emphasizes items listed under number 1, c and d above.

3. Specialist may be employed by local school districts augmenting present educational programs. Emphasizes items listed in number 1, c and d above.

4. Specialist may be employed by public or private agencies to perform administrative type tasks:

   a. managing any number of group homes or apartments
   b. overall program development and assessment
   c. conduct staff meetings
   d. attend local and state meetings
   e. personal-professional growth

The above represents a wide range of community services for the handicapped. The Life Management Program is designed to provide the skills and competencies required to promote effective community based residential programs. He/she will be expected to relate to other professionals such as psychologists, sociologists, teachers and medical people in a knowledgeable and intelligent manner and as an advocate for the handicapped.

## III. PROJECTION OF RESOURCES REQUIRED FOR THE PROGRAM

A. Faculty: None

Other: None

B. New Resources:

New faculty to be hired in the department or school: None

New faculty to be hired in supporting departments or schools: None

Overload in department/school: None

Overload in supporting department/school: None

Travel costs in excess of departmental allocations: use of state car to supervise field practicums or automobile reimbursement if state car not available; currently less than $300 per semester per full-time supervisor. Note: Present supervisors for pre-student teaching experiences and for student teaching will be utilized. Life management students will be placed in close proximity or in the same facility as the other field experiences. Consequently, they may be supervised by faculty who are already in the field supervising students in current programs.

Released time: Supervision of students in field experiences

Library cost: Appear adequate to initiate program

Instructional materials and equipment: None

## IV. FACILITIES

A. College: Does the program require facilities beyond those currently used by other departmental programs? No

B. External: Does the program require facilities outside the college beyond those currently used by other departmental programs? Yes

Suggested sites: Polk State Center
Gertrude Barber Center
Stairways, Inc.
The Hearth
Crawford County Mental Health/Mental Retardation

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG, PENNSYLVANIA 17120

OFFICE OF MENTAL RETARDATION
PETER P. POLLONI
DEPUTY SECRETARY

TELEPHONE
AREA CODE 717,
783-8300

June 20, 1977

Mr. John Mannino
Special Education Department
Edinboro State College
Edinboro, Pennsylvania 16444

Dear Mr. Mannino:

I have just reviewed your Bachelor of Science in Special Education: Life Management for the handicapped proposal and am taking the liberty of expressing some of my thoughts regarding it.

As our community living arrangement program for the mentally retarded expands in the years ahead, there will be an increasing need among private agencies providing contractual residential services to our Department for college graduates with multiple skills, cutting across the traditional disciplines.

Graduates will need background knowledge of physical and mental handicaps, their rehabilitation implications and the appropriate utilization of generic resources for successful social integration. Some business knowledge will be necessary: how to prepare budgets; sign leases and contracts; hire, train and supervise personnel; operate apartment complexes; and, provide public relations function.

Most positions will be found in the private sector among agencies furnishing community living and work programs for our clients. As our programs expand so will the need for trained personnel. Some positions may be found in our County Mental Health-Mental REtardations Centers thoughout the Commonwealth.

I feel a great deal of the potential practical benefit accruing to your students will depend upon the quality of training gained through the field practicum exposures and the management internship. I might suggest you utilize a second MH/MR site for comparison purposes.

Perhaps with intensive concentration on the limited number of students to be enrolled initially some new elements might be incorporated as you proceed. I have one major concern - what you are seeking, and what we need, is a specifically trained individual, not just a teacher retread. With proper safe guards and careful planning Edinboro State College could build a solid program and become a leading supplier of life management specialists.

If I can be of any service as the program develops feel free to contact me. Wishing you the best of luck, I remain

Sincerely yours,

Mel Knowlton

Mel Knowlton
Director
Bureau of Community Programs

CRAWFORD COUNTY CHAPTER
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS
P. O. Box 628 Meadville, Pennsylvania 16335 Telephone 814 724-7346

President
KARRIN MANCUSO

Executive Director
GARY STRAWBRIDGE

March 30, 1977

Mr. John Mannino
Leader Clinic
Special Education Department
Edinboro State College
Edinboro PA 16444

Dear Mr. Mannino:

The concept of a Life Management Curriculum offering a degree is a far-sighted development. In the time of deinstitutionalization and Community Living Arrangement, there is a great unfulfilled need for persons with a background and understanding of the problems inherent in this normalization process.

In Crawford County we are experiencing the developmental problems that accompany group home establishment. With certified Life Management personnel available, I am certain in the future some of our current difficulties will be solved more effectively.

Our endorsement is enthusiastic and we wish you much success in this most needed aspect of long-range planning.

Sincerely,

Karrin Mancuso

Karrin Mancuso
President

KM:msv

THE MILTON S. HERSHEY MEDICAL CENTER
THE PENNSYLVANIA STATE UNIVERSITY
HERSHEY, PENNSYLVANIA 17033

Department of Behavioral Science

717 534-8487 or 8262

March 24, 1977

Dr. John Mannino
Edinborough State College
Department of Education
Edinborough, PA 16412

Dear John,

This letter is concerning the need for a bachelor degree program in Life Management Services for the Handicapped. Based on my experiences in training in the area of developmental disabilities throughout the Commonwealth, I believe that such a program is very much needed. Similar programs, such as the one at Clarion State College, have been very well received but have not even begun to meet the need. I hope that it will be possible for you to initiate such a program at Edinborough.

Sincerely,

Peter S. Houts, Ph.D.
Associate Professor

PSH:sli

# APPENDIX E

## Competencies Listed by Function: An Alternative Approach to Classification

The competencies in this section have been organized by function by David Sigetich.[1] It should be noted that the competencies in the main text have been revised since these initial efforts; thus there is some discrepancy between the exact wording of the competencies and the exact competencies included in both sections. Moreover, some competencies have been added to the main text since Mr. Sigetich's organizational efforts. This does not diminish the value of Mr. Sigetich's contribution: to demonstrate another relevant way of organizing competencies according to an individual training program's needs.

The competencies have been organized by Mr. Sigetich into the following functional areas:

A. Creates and maintains normalizing living arrangements.

B. Designs, manages, conducts and evaluates training programs.

C. Provides physical care.

D. Relates with others - one to one.

E. Relates with others - in a group.

F. Knows resources and legislation.

G. Identifies the physical, psychological and social aspects of developmental disabilities.

H. Maintains own effectiveness.

I. Advocates for those who need advocacy.

J. Supervises and administers people and programs.

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[1] Coordinator of the Mental Retardation Counsellor Programme, Centennial College of Applied Arts and Technology, Scarborough, Ontario MIL 32C. Most references in this appendix may be found in Chapter 4 and/or Chapter 8.

## COMPETENCIES

### A. Creates and Maintains Normalizing Living Arrangements

1. List and describe the basic needs of all individuals using a recognized theory of needs as a structure (e.g., Maslow, Glasser).

2. Explain why exceptional individuals often have a greater than normal need for social reinforcement and interaction and less tolerance for frustration or new experiences.

3. Detail the affective needs of an exceptional individual given a specific set of data, and relate the needs identified to a recognized theory of human needs (e.g., Maslow).

4. List the needs of all individuals in our society, as specified by a recognized theory of needs and describe how well-adjusted members of society go about meeting their needs.

5. Describe the obstacles put in the way of exceptional individuals in meeting their own needs, and list possible ways for removing or reducing the obstacles identified.

6. Explain the significance of resident behavior as it relates to: a) social adaptability, b) cognitive performance, c) task achievement.

7. Identify personnel actions which help to:
    a. establish and maintain behavior
    b. decelerate or eliminate behavior

8. Distinguish among the terms 'deviance,' 'deficit,' and 'handicap.'

9. Explain how a 'deficiency' is turned into a 'handicap.'

10. Articulate a personal philosophy for dealing with exceptional individuals which reflects: respect for their feelings and needs and those of their families; comprehension of the psychological stresses with which they and their families must deal; realization that all individuals have positive potential.

11. Define the term 'cloak of competence' and predict particular problems that may develop with a specified developmentally disabled person engaged in compensating, outside the CLA, given a specific set of data.

12. Identify five serious misconceptions the general public has about specified exceptionalities and delineate at least three strategies for effectively eliminating or reducing the misconceptions cited.

13. Specify common re-entry problems in moving from an institution to an ALA and delineate strategies for eliminating the re-entry problems identified.

14. Describe the effects of institutionalization and support the effects described by reference to research and to a specific resident.

15. Enumerate the effects of labelling and support the effects enumerated by reference and authoritative opinion.

16. Define normalization as defined by Nirje, Wolfensberger and others, and give the rationale provided by the authorities cited for advocating adherence to the normalization principle.

17. Cite authoritative criticisms of the normalization principle and provide examples of its misuse or misinterpretation; find actual examples of the misuse or misinterpretation in a specific service. Present the rationale for classifying events, situations or conditions as 'misuse' or 'misinterpretations' of the normalization principle.

18. Describe the major components of the normalizatin principle delineated by Wolfensberger.

19. Diagram Deno's cascade concept of the 'least restrictive environment' and specify what criteria and procedures would be appropriate for moving an individual from one level to another.

20. Document how expectancies can influence client and staff behavior and the opportunities available to both.

21. Describe from observation how an ALA can subtly take on many of the restrictive characteristics of an institution.

22. List the rights of an exceptional individual and identify how an ALA may impinge on them.

23. Define 'deviancy image' and explain how it relates to expectancies for the client, the manner in which staff and others relate to the client, and its effects on opportunities available.

24. Define 'dignity of risk' and, from direct observation, provide an exemplary illustration and an illustration of its misuse and/or misinterpretation.

25. Provide exemplary illustrations of how normalization should affect dress, rhythm of day, work, rights, and method of address, given a specific set of data.

26. Explain how social attitudes are developed, how they influence services and what strategies have proven effective in modifying or neutralizing attitudes that are detrimental to the development of exceptional individuals and their families.

27. Provide examples of how society's attitudes affect the availability of services for exceptional individuals with specified exceptionalities.

28. Explain where within the concept of 'least restrictive environment' the ALA should be placed and if and why the resident should be involved in the formulation and evaluation of exit criteria.

29. Trace the historical and philosophical reasoning which provides the impetus for normalization.

30. Explain the important distinctions between and the implications of Gold's concept of a basically intact system vs. a nonworking system with some intact parts.

31. Distinguish among deviance, disability and handicap and explain the importance of distinguishing among the concepts.

32. Explain how utilization of the word 'handicap,' and the concept, in reference to particular individuals can result in diminished opportunities and self-fulfilling prophecies.

33. Identify facets of behavior, situations, conditions of appearance that signal deviance and develop strategies for reducing or eliminating the negative attention arising from these signals, given a specific set of data.

34. Generate a series of questions to assist in identifying stimuli indicative of deviance.

35. Distinguish between normalization as a means and as an end and provide a rationale for considering normalization as a means, as an end, or both.

36. Distinguish between being involved in a community (social integration) and living in an ALA.

37. Explain the importance of social integration and provide a plan to socially involve an individual resident in the community, given a specific set of data.

38. Specify when a highly prosthetic environment is necessary and the precautions which should be taken to reduce the visibility of the prostheses.

39. Specify the arguments for and against using culturally unnatural and/or artificial intervention strategems or prosthetic systems and devices for meeting client needs

(e.g., systematically using food instead of verbal praise to foster a desired behavior or using a specially equipped automobile with a special license designating an exceptional individual).

40. Develop a chart detailing the major obstacles for and against physical and social integration of residents in a community, the resources available to reduce resistance and strategies particularly appropriate, given a specific set of data.

41. Detail the procedures for assessing particular generic services.

42. Given a description of a particular community, list and describe the behaviors and attributes that need to be changed for residents to interact successfully with the community; describe a strategy for changing the attitudes and behaviors listed.

43. After observing in a particular community describe and evaluate the community attitudes and behaviors toward exceptional populations which need to be modified for successful resident adjustment to occur.

44. Identify strategies for motivating residents to discover and utilize community-based generic services for recreation and leisure time activities.

45. From direct observation, identify 6 dependency-producing practices in one or more ALAs and list ways of ameliorating them. Implement one.

46. Establish and maintain practices and interactions with residents which reinforce age-appropriate behavior.

## B. Design, Manage, Conduct and Evaluate Training Programs

1. Specify the legitimate concerns of resident advisors with respect to diagnosis and case management, and program planning.

2. Define the role of the resident advisor *vis-a-vis* the case management team.

3. Describe the essential components of a case management plan and indicate who is responsible for each of the components.

4. Define the basic terminology used by professionals critical to the development and implementation of a case management plan.

5. Obtain relevant information from case management team and paraphrase it to the satisfaction of the team.

6. Contribute information concerning resident needs, progress and program content to the case management team, to the satisfaction of the team.

7. Describe resident behavior in phenotypic terms and present data to support major contentions.

8. Lead an interdisciplinary group to a consensus plan for working with an individual resident, given a specific set of data.

9. Define the role of the resident advisor vis-a-vis individual program planning.

10. List the responsibilities of the resident advisor for program planning, monitoring and evaluation.

11. Present a rationale for involving the resident or his representative fully in formulating program objectives.

12. State the purposes and advantages of interdisciplinary program meetings which involve the resident and/or his parents.

13. List three possible dangers of involving a resident and/or his parents in an individual program planning meeting, and provide strategies for reducing or eliminating those dangers.

14. List the rights of residents with respect to privacy of records, individual program planning and freedom of movement within an ALA program.

15. Conduct self to maintain the rights identified in number 14.

16. Describe and evaluate own contributions to an individual program planning meeting as a resident advisor.

17. Write a set of guidelines for suggesting that an interdisciplinary program planning meeting is necessary, once an initial meeting has been held. Call the meeting.

18. Explain how the following individual program plan elements relate to each other: assessment of resident's strengths, needs and weaknesses; the interdisciplinary program planning conference; long-term and short-term objectives; intervention strategies; evaluation system; review process.

19. Specify those individuals who should be involved in designing and refining an individual program plan for a resident.

20. Define the role that should be played by the individual program planning team chairman. Implement that role at an actual meeting.

21. Define the responsibilities of each member of the program planning team to the team and to the planning process. Implement the role of resident advisor at such a meeting.

22. Explain why intervention plans and procedures should begin at the resident's level of functioning, and why they should not remain at that level.

23. State the purpose and benefits of an individual program plan; list and define the elements of such a plan.

24. Specify the kinds of data that are necessary for developing an initial program plan, and specify sources for such data.

25. Unobtrusively observe a resident, describe his behavior in phenotypic terms, and present qualitative and quantitative data to support major contentions.

26. List comprehensive criteria for prioritizing a resident's needs, and, given a particular set of data, prioritize a resident's needs in a manner reflecting the criteria presented.

27. List the advantages of placing time limits on long-term and short-term objectives.

28. Given a specific set of data, set time limits for long- and short-term objectives for a particular resident.

29. Distinguish between short- and long-term objectives, specify how they relate to each other, and provide examples of each which clearly demonstrate a high degree of relatedness.

30. State and prioritize a set of long term and short term objectives, adhering to the Mager format, given a specific set of data.

31. Draw conclusions from a given set of data about a resident; from those conclusions formulate long- and short-term goals, prioritize them, and establish strategies for program implementation.

32. Describe the essential components of an individual program plan, delineate responsibilities for the information needed, and indicate who is responsible for finalizing each of the components.

33. State why it is necessary for involved parties to know exactly what their responsibilities are vis-a-vis the agreed upon program objectives, and to agree to meet their responsibilities.

34. At a particular program planning team meeting, ensure that each team member can describe his/her responsibilities for the program under consideration, and obtain commitment from each team member to execute the agreed-upon function(s).

35. Describe the basic procedures used by specified professions usually involved in individual program planning in gathering data and generating recommendations.

36. Describe the steps an individual program planning team member should take when disagreeing with the data presented, the conclusions drawn, and/or the recommendations made.

37. Diagram the informal appeal and due process procedures a parent, a client, or other interested parties should follow when disagreeing with an individual program plan. Advise the interested party.

38. List a series of questions and procedures for ascertaining whether particular intervention strategies have been effective with individual residents. Using the list generated, evaluate the effectiveness of a set of intervention strategies.

39. List a series of questions and procedures for ascertaining whether an individual program planning meeting has been successful. Using the list generated, evaluate the effectiveness of an actual individual program planning meeting.

40. Specify the reasons for a resident not reaching the objectives established, given a specific set of data and an actual resident.

41. Identify several alternative courses of action to be followed if residents are not achieving the agreed-upon short-term or long-term objectives. Given a specific set of data and an actual resident, choose and implement the best course of action.

42. Describe the obstacles put in the way of exceptional individuals and list possible strategies for removing or reducing the obstacles identified.

43. List some guidelines for working with developmentally disabled individuals which will assist them in satisfying their needs without depriving others of adequate opportunity to meet their needs.

44. Examine case study data and specify the needs an individual is trying to satisfy with inappropriate behavior, using a specified theory of needs for analyzing the data.

45. Observe and record resident behavior without seriously affecting it.

46. Accurately observe and record behavior.

47. List and define behaviors considered representative of specified exceptionalities.

48. Identify and describe resident and resident advisor behavior in phenotypic terms.

49. Evaluate observed performance on the basis of specific criteria.

50. Develop criteria against which to evaluate behavior.

51. Explain the significance of resident behavior as it relates to:

    a. social adaptability;
    b. cognitive performance;
    c. task achievement.

52. Explain how a resident's social adaptability influences his cognitive and occupational performance.

53. Define motivation and explain its development and maintenance.

54. Analyze a particular resident's behaviors in terms of resident motivators.

55. Identify personnel actions which help to:

    a. establish and maintain behavior;
    b. decelerate or eliminate behavior.

56. Use appropriate terminology to articulate clearly a resident's:

    a. levels of achievement
    b. deviances affecting social, cognitive and emotional functioning.

57. Analyze an interactional or instructional situation with reference to a structured theory (e.g., H. C. Quay model).

58. Distinguish between content and process task analysis.

59. Task analyze a series of activities required of a resident using the framework of a prominent task analysis procedure (e.g., Hakim, Johnson).

60. Explain to significant individuals involved with the resident how specific tasks should be broken down and presented to the resident, in a manner that is translated into action.

61. Demonstrate how to fractionalize a complex task into components that are manageable by a particular resident.

62. After generating a relevant task analysis, employ it to teach the resident the task, bringing the resident to criterion in the predicted time.

63. Define the four major types of reinforcement schedules, and describe the uses of each.

64. Given a particular resident and a relevant target behavior, select the appropriate reinforcement schedule to maximize acquisition.

65. Describe how to fade reinforcements.

66. Given a particular resident in the acquisition phase of training, design reinforcement procedures to fade reinforcements to a normal level without extinguishing the newly acquired behavior.

67. Teach a resident to generalize a particular target behavior to several appropriate situations.

68. Identify the experiences and opportunities needed by normal adolescents for normal development.

69. Specify how individuals with specific developmental disabilities may not be able to involve themselves fully with the needed experiences identified above.

70. Generate appropriate strategies for providing the necessary experiences for normal development as described above.

71. Explain the significance of the following statement: Adolescence is not only a function of age, but of cognitive and experiential maturity.

72. Define the basic terms and concepts used by the instructor and course materials in the discussion of behavior management. (BC 1).

73. Explain the basic theories/principles of behavior management alluded to by the course instructor and the course materials. (BC 2).

74. Operationally define specific behaviors observed in the presence of instructor and/or classmates. (BC 4).

75. Compare the differences, similarities and implications for modifying behavior of prominent theories of behavior management/change. (BeM 4).

76. Specify and define the prominent variables that influence group and individual behavior; explain how these variables interact. (BC 8).

77. Delineate criteria for ascertaining whether or not particular individuals manifest behavioral difficulties:

    a. specify necessary considerations for establishing criteria for inappropriate behavior;

  b. specify considerations for ascertaining if problem behavior is a reflection of a particular behavior. (BeM 6).

78. Discuss ethical considerations relevant to:

    a. deciding that a behavior needs to be controlled/modified;
    b. choosing the procedures for control/modification of a behavior;
    c. releasing information;
    d. obtaining consent (BC 16)

79. Discuss the causes of and generate remedial solutions to particular behavioral problems observed, within the framework of prominent behavioral management/learning theories. (BeM 8).

80. Analyze the resident's environment to a degree sufficient to isolate particular variables responsible for:

    a. maintaining target behaviors selected for reduced emission or elimination;
    b. inhibiting the development of desired behaviors. (BeM 9).

81. Create and manipulate the environment so as to:

    a. lessen the occurrence of a behavior selected for reduced occurrence or extinction;
    b. increase the response rate of a desired behavior;
    c. assist the learner in developing new behaviors;
    d. maintain behavior at a given rate. (BeM 10).

82. Generate specific strategies for helping people to overcome problems of:

    a. aggression
    b. impulse control
    c. hyperactivity
    d. distractibility
    e. withdrawal
    f. inadequate social perception
    g. poor interpersonal relationships
    h. confidence and self-worth
    i. poor motivation

83. Develop behavior management strategies that enhance the probability of social progress and emotional stability.

84. Implement four of the strategies developed in B 83.

85. Develop and implement four different strategies for helping individuals increase their self-control in specified situations.

86. Identify 5 strategies useful in coping with stress.

87. Utilize two of the strategies identified in B 86.

88. Instruct residents in:

   a. grooming skills
   b. hygiene skills
   c. meal preparation
   d. housekeeping skills
   e. laundry skills
   f. sign recognition
   g. menu planning & nutrition
   h. money use
   i. consumerism
   j. budgeting
   k. purchasing
   l. credit
   m. language skills
   n. reading
   o. travel training
   p. use of hand tools
   q. gardening
   r. home maintenance
   s. use of community resources
   t. time management
   u. prevocational skills
   v. first aid
   w. sexuality
   x. contraception
   y. interpersonal skills
   z. health care

89. Describe a specified number of techniques useful in teaching a person to generalize a behavior to other appropriate situations; implement a specified number of these.

90. Develop and use one or more monitoring systems to be used by resident advisors that will clearly and accurately represent progress made.

91. Design and implement a specified number of strategies for motivating relevant individuals to cooperate with the behavioral management/modification strategies being considered or employed.

92. Analyze task requirements and present tasks in such a manner that targeted individuals are able to accomplish the task presented without exhibiting frustration or dissatisfaction.

93. List and justify and implement three discrete ways of motivating recalcitrant residents to become involved in home and community activities.

94. Write an individual habilitation plan for re-integrating a client into the community, given specific data.

95. Describe four general strategies for socially involving family, institutionalized residents and those now living in an ALA, in the community.

96. Describe how the principle of normalization may be applied to therapeutic intervention (e.g., the selection of reinforcers used in a behavior management program).

97. Ensure each behavior management and acquisition program adheres as closely as possible to the principle of normalization.

98. Specify the arguments for and against using non-culturally normative and/or artificial intervention stratagems or prosthetic systems or devices for meeting client needs.

99. Explain how Wolfensberger's concept of normalization might be beneficially applied in preparing specified exceptional individuals for success in the community.

100. Develop a series of activities to make exceptional individuals more aware of local services and opportunities and more apt to involve themselves with those identified. Implement a specified number of these activities.

101. Portray behavioral data using graphs.

102. Portray behavioral data using Precision Teaching (Standard Behavior) Charts.

103. Define and use a continuous observation procedure.

104. Define and use a time sampling observation procedure.

105. Define and use an event recording procedure.

106. Define and use an interval recording procedure.

107. Define each class of prompt, and rank order in terms of descending saliency:

    a. physical
    b. verbal
    c. gestural

108. For a specified training situation, determine the most suitable prompt(s) and implement.

109. In each training program written, identify how prompts are to be faded.

110. Write each training program so that it can be carried out by a stranger and yet obtain substantially identical progress and behavioral data as if you were implementing it, using substantially identical methods.

111. Design and implement a specified number of training programs utilizing each of the following:

    a. shaping
    b. forward chaining
    c. backward chaining

112. Identify criteria for determining which program methodology to utilize.

113. For specified residents and specified target behaviors, select and justify training methodology.

114. Identify the advantages and disadvantages of having a resident collect his/her own behavioral data.

115. Design and implement a program employing resident self-collection of data.

116. Define each of the following program types:

    a. task-based*
    b. criterion-based*
    c. condition-based*

117. Identify criteria for determining which program type is appropriate for a specified set of program goals.

118. Design and implement a specified number of training programs using each of the following program types:

    a. task-based
    b. criterion-based
    c. condition-based

C. Provides Physical Care

1. Specify several common physical ailments of adulthood at various ages for specified disabilities.

2. Washes hands when necessary using approved technique.

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*For definitions, see Sigetich, D. W. Goal Setting: A Handbook For The Design Of Individual Program Plans, 4th Ed. Scarborough, Ontario: Centennial College of Applied Arts and Technology, 1978.

3. Makes a comfortable unoccupied bed.

4. Makes a comfortable occupied bed.

5. Assesses and records accurately:

    a. oral temperature
    b. auxillary temperature
    c. rectal temperature
    d. radial pulse
    e. carotid pulse
    f. respiration

6. Demonstrates care of equipment for vital sign assessment.

7. Provides hygenic care:

    a. skin (including perineum)
        - tub
        - shower
        - bed bath
    b. mouth, dentures
    c. hair
    d. eyes
    e. nails

8. Feeds people with dignity

    a. adult
    b. child
    c. multi-handicapped person

9. Assists with dressing and undressing while demonstrating warmth and awareness of client's abilities.

10. Lifts and moves a client in a safe and comfortable manner, using appropriate body mechanics:

    a. from floor to bed
    b. from floor to chair
    c. from one side of bed to the other
    d. from bed to stretcher
    e. from stretcher to bed
    f. from supine to sitting position
    g. from sitting to supine position
    h. into and out of a bathtub
    i. from wheelchair to toilet
    j. from wheelchair to chair
    k. from toilet to wheelchair

11. Positions client, using appropriate comfort devices, in:

    a. Fowler's position
    b. supine position
    c. lateral position

12. Provides Range of Motion exercises
    a. active
    b. passive

13. Places a client on bedpan in bed, removes, provides perineal care.

14. Tests urine for sugar and acetone.

15. Prepares, administers and records:
    a. eye drops
    b. eye ointment
    c. suppositories
    d. topical medications

16. Following approved, standardized procedures, prepare, administer and record:
    a. liquid medication (oral)
    b. tablet medication (oral)

17. Identifies and explains use of equipment required for:
    a. administration of oxygen
    b. administration of enema (fleet, soapsuds)
    c. suctioning
    d. shampoo in bed
    e. application of heat
    f. application of cold

18. Demonstrates:
    a. administration of enema
    b. shampoo in bed
    c. application of heat
    d. application of cold

19. Identifies situations requiring use of above procedures.

20. Practices first aid to a specified standard (Red Cross Standard Basic).

21. Changes a dressing.

22. Provides appropriate care of decubitous ulcer.

23. Cares for equipment and supplies.

24. Plans a daily menu for 5 people using a recognized standard of nutrition.

25. Identifies seizure activity: grand mal, petit mal, psychomotor.

26. Provides appropriate care following and during a seizure.

27. Can identify and motivate clients to participate in, a regimen of exercise appropriate for a healthy:

    a. older adult
    b. middle years adult
    c. young adult
    d. adolescent
    e. child 10 - 14 years

28. Observes, reports and records signs and symptoms of illness.

29. Verbally describes medical history and current treatment for a selection of residents.

30. Verbally describes classes of drugs, such as major tranquillizers, minor tranquillizers, anti-depressants, anti-convulsants, antibiotics, analgesics, etc.

31. Verbally describes major uses and dosage range for a selected set of commonly used drugs.

D. Relates with Others - One to One

1. Appropriately initiate contacts with exceptional individuals.

2. Initiate contacts that are generally appropriate to the needs of the exceptional person(s) and to the situation(s).

3. Specify and describe, in depth, the affective needs of exceptional individuals.

4. Interact with exceptional individuals in a manner that reflects:

    a. respect;
    b. genuine concern;
    c. understanding of the individual's limitations and capacities;
    d. lack of fear or alienation.

5. Deal with exceptional individuals in a concrete manner when appropriate.

6. Communicate effectively with exceptional individuals.

7. Maintain a close working and/or informal relationship with an exceptional individual.

8. Point out mistakes or erroneous understandings on the part of exceptional individuals in an unabrasive emphatic and respectful manner that reflects an understanding of the exceptional individual's capacities and limitations.

9. Handle confrontation situations:

    a. in a manner that is instructive for the exceptional individuals involved.
    b. without losing his professional perspective of concern, respect, understanding, and warmth.
    c. with the realization that confrontation is sometimes necessary.
    d. constructively.

10. Interact with exceptional individuals in a manner that facilitates their:

    a. social development
    b. emotional development
    c. cognitive development
    d. psychomotor development

11. Explain:

    a. the objective of the particular program he/she is involved in;
    b. where the particular program fits within the service delivery system needed by the community.

12. List and describe behaviors considered representative of specified exceptionalities.

13. Identify and describe resident and resident advisor behavior in phenotypic terms.

14. Describe the major growth patterns occurring during normal adolescence in the areas of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

15. Explain the difficulties or obstacles encountered by adolescents with specified developmental disabilities in dealing with the normal problems of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

16. Identify the obstacles encountered by a developmentally disabled adolescent in dealing with normal developmental difficulties, given a specific set of data.

17. Distinguish between normal and abnormal adolescent difficulties and behaviors in the areas of physical development, emotional stability, the search for identity and independence, social and social-sexual development.

18. Formulate and respond to the basic questions asked by normally maturing adolescents about themselves.

19. Specify how the normal questions usually posed by normally maturing adolescents about themselves are influenced by particular developmental disabilities, given a specific set of data.

20. Explain the significance of the following statement: "Adolescence is not only a function of age, but of cognitive and experiental maturity."

21. Distinguish between the terms 'adolescent' and 'adult' and describe how specified exceptionalities may influence the definitions given.

22. Specify behavioral indices (e.g., laughter, grief, withdrawal) that a resident is having a problem with outside the ALA which may necessitate attention by the resident advisor.

23. Effectively share behavior management and program techniques and strategies with residents, parents and relevant professionals to the degree that, and commensurate with capacity they:

    a. understand the goals of the program;
    b. understand their role in relation to the program.

24. Give and accept nonevaluative feedback.

25. Specify and describe the usual parental responses to learning that they have given birth to a developmentally disabled individual.

26. Convey understanding and acceptance to parents.

27. Communicate with parents about their offspring's current programs, progress and plans.

28. Attend, identify and respond to nonverbal cues.

29. Clarify role expectations with residents, parents, other workers.

30. Terminate relationship with resident appropriately.

## E. Relates with Others - In a Group

1. Identify basic factors which inhibit the free sharing of information and opinions in small group situations (e.g., factors that arouse defensiveness).

2. Specify how language and memory factors often distort intended meaning and polarize problem solving groups.

3. List basic reasons for resistance to change within a small group situation and detail actions one can take to reduce resistance. Implement those actions.

4. Identify and describe factors generally acknowledged to be responsible for individual behavior in small groups (e.g., reinforcement history, present needs, stereotyped images, individual fantasies, reference to external groups).

5. Explain a basic model of group communication which describes the basic conditions for successful communication, the elements of successful communication and problem solving, the characteristics of an effectively functioning group (e.g., as outlined by Anderson).

6. Analyze the basic difficulties a group is having communicating effectively, and devise and implement effective strategies, given a particular group.

7. Specify the actions one can take to enhance the attractiveness and functioning level of a group. Implement a specific set of those actions, given a specific group.

8. Lead a brainstorming session which adheres to the four basic rules of such sessions.

9. Explain the difference between 'consensus' and 'compromise' and indicate situations appropriate and inappropriate for both.

10. Lead an interdisciplinary group to consensus.

11. Give and accept nonevaluative feedback.

12. Describe the elements of a systematic problem solving process.

13. Detail, in step-by-step fashion, how a particular specified problem-solving procedure can be used to identify and resolve a problem, given a particular set of data.

14. Given a particular problem and a particular group, lead a small group in identifying and resolving a problem.

F. Knows Resources and Legislation

1. Verbally identify, for every practicum setting:

   a. the person or body in charge of the agency
   b. the person in charge of the practicum setting
   c. legislation, if any, controlling the setting's operation
   d. services provided

2. Describe the legitimate functions of professions usually involved in the diagnosis and case management of residents.

3. List the basic questions specified professions are or should be prepared to answer, vis-a-vis the needs of residents.

4. Describe the basic procedures used by specified professions usually involved in diagnosis and case management in gathering data and generating recommendations.

5. Identify those individuals who should be involved in designing and refining a case management plan for a resident.

6. Define the basic terminology used by professions critical to the development and implementation of an individual program plan.

7. Describe the services needed by exceptional individuals and their families to function effectively:

   a. at home
   b. in school
   c. in the community

8. Describe those services needed by exceptional individuals and their families which are available in the community within which the practicum is received.

9. Cite and discuss the conditions requisite for effective service to exceptional individuals and their families.

10. Detail the procedures for assessing particular generic services.

11. Given a description of a particular community, list and describe the behaviors and attributes that need to be changed for residents to interact successfully with the community; describe a strategy for changing the attitudes and behaviors listed.

12. After observing in a particular community, describe and evaluate the community attitudes and behaviors towards exceptional populations which need to be modified for successful resident adjustment to occur.

13. Identify and explain a minimum of three misconceptions which individuals often hold about specific exceptionalities and describe the effects of the specified misconception.

14. Evaluate in detail a local community resource designed to assist exceptional individuals in developing competencies to meet their social, emotional, career, physical and educational needs.

15. Specify and explain how community resources (e.g., businesses, sheltered workshops, social and rehabilitative agencies) should be used to assist in the life-adjustment of exceptional learners.

16. Specify the legal rights of exceptional individuals for access to community and educational services, vocational preparation, assistance and employment.

17. Provide examples of how society's attitudes affect the availability of services for exceptional individuals with specified exceptionalities.

18. Identify major pieces of legislation impacting the field of developmental disabilities, and describe the impact of each.

19. Identify landmark court decisions in the field and describe their impact on the field.

20. Verbally identify sources of revenue for the exceptional adult (i.e., allowances, pensions, etc.).

21. Describe the characteristics of total institutions.

22. Verbally identify the characteristics of ALAs that resemble those of a total institution.

23. Identify the place of the ALA in the state, regional and federal service systems for exceptional individuals.

24. Verbally identify where the ALA obtains funding, and to what extent.

G. Identifies the Physical, Psychological and Social Aspects of Developmental Disabilities

1. Describe the obstacles put in the way of exceptional individuals in meeting their needs and list possible strategies for removing or reducing the obstacles identified.

2. List some guidelines for working with developmentally disabled individuals which will assist them in satisfying their needs without depriving others of adequate opportunities to meet their needs.

3. Explain the significance of resident behavior as it relates to:

   a. social adaptability
   b. cognitive performance
   c. task achievement

4. Distinguish among the terms 'deviance,' 'deficit' and 'handicap.'

5. Explain how a 'deficiency' is turned into a 'handicap.'
6. Describe the medical and psychological bases for specified exceptionalities.
7. Broadly explain how the psychological and instructional characteristics of exceptional individuals are evaluated.
8. Present arguments in support of and oppositional to the current special education labeling and classification systems.
9. Explain the effects exceptional individuals have upon their families and surroundings, given specific data.
10. Specify what can be done to improve the attitudes of family members and society at large toward exceptionality.
11. Specify the characteristics and causes of learning problems, adjustment problems, communication problems, sensory problems, and motor problems.
12. Define basic terminology in the field of developmental disabilities as specified by the instructor.
13. Distinguish between instructionally relevant and medically relevant information and provide examples of each which clearly demonstrate its particular relevance.
14. Explain how social attitudes are developed, how they influence services and what strategies have proven effective in modifying or neutralizing attitudes that are detrimental to the development of exceptional individuals and their families.
15. Define specified exceptionalities and explain the medical, psychological and sociological causes of the specified exceptionalities, where known. In presenting the causative factors, distinguish between professionally agreed-upon fact, well-developed theory, and opinion.
16. List the primary behavioral and physical characteristics of specified exceptionalities and distinguish between those characteristics which are likely to be constitutionally or genetically based and those which are likely the result of environmental factors.
17. Explain the rationale for and the implications of the statement: deficiencies do not reside exclusively within the individual and are not exclusively the result of a defective constitution. (Smith & Neisworth, 1975).
18. Explain the implications for individual program planning of the statement: human development is a continuous process in which the individual's constitutional and genetic endowment and reinforcement history continuously interact with the environment to influence his behavior.

19. Diagram how constitutional and genetic factors interact with experience and opportunity to influence the behavior patterns of an individual with a disability.

20. Provide at least four reasons why traditional classification and labeling schemes (e.g., psychotic, mentally retarded) are inadequate and often misleading for determining individual needs, proper placement, and appropriate intervention strategies.

21. Distinguish between the terms 'incidence' and 'prevalence' and provide incidence and prevalence figures for the percent of the population exhibiting specified disabilities at different ages (e.g., infancy, pre-school, adolescence).

22. Specify the degree of confidence that can be placed in current incidence and prevalence figures for specified exceptionalities and provide a rationale for the conclusion reached.

23. Select a theory of learning and development and use it to explain why individuals with the same classificatory labels (e.g., severely retarded, epileptic) display different personalities, react differently to situations and progress at varying rates toward specified objectives.

24. State how well 'experts' can predict an exceptional individual's future accomplishments and provide research and authoritative opinion, as well as that taken from your own observations, to support the position taken.

25. Explain what is meant by the concept that many exceptionalities or components of a deviance are transitory and specify the implications of such a position for individual program planning (e.g., the verbal aggressiveness of a cerebral palsied adult may be transitory but his involuntary motor movements are likely to be permanent).

26. Describe, in broad terms, the general process of and the procedures employed in classifying an individual as developmentally disabled.

27. Illustrate how the same individual, exhibiting the same attributes, would be given a different label by a variety of professions and would then be eligible for a different set of services and have a different prognosis.

28. List the basic assessment instruments and procedures used for classifying persons as developmentally disabled and summarize the limitations of the instruments and procedures identified, with reference to research and authoritative opinion.

29. Construct a chart identifying factors known or presumed to contribute to the development and maintenance of a specified disability and describe the basic procedures or intervention strategies currently employed for reducing, eliminating or preventing those factors.

30. Define and give an example for each of:

    a. primary prevention
    b. secondary prevention
    c. tertiary prevention

31. List and give information about the causation, symptomatology, mortality, degree of involvement and treatment or prevention for 15 most common syndromes among the developmentally disabled.

32. Distinguish between phenotypic and medical definitions of specified deviancies and disabilities and illustrate the utility and limitations of each definition.

33. Trace the reaction patterns of families to having a developmentally disabled child and identify how this may add to or lessen the impact of the disability on the child.

34. Define 'mental retardation' using both AAMD's and Marc Gold's definitions; compare and contrast, showing implications.

H. Maintains Own Effectiveness

1. Seeks information about policies and procedures at practicum setting.

2. Frequently checks communication boards, communication books, message boxes, or other means of communication among staff and/or students on placement.

3. Manages own time so that assigned work is completed in time specified, is on time, and allocates time effectively among competing demands.

4. Seeks and utilizes supervision from staff members, supervisor and faculty.

5. Carries out self-assessment periodically, identifying strengths and areas for further development.

6. Identifies, with supervisor, ways of remediating needs and implements one or more.

7. Exchanges views, techniques, approaches, information with other professionals.

8. Attends one or more field-related conferences per year.

9. Detects feelings of lassitude and indifference in self, and identifies own 'burnout' status.

10. Discovers and utilizes mentor and colleagues in organization.

11. Reads field-relevant journals, books and other material.

12. Joins a relevant professional organization and attends meetings.

## I. Advocates For Those Who Need Advocacy

1. Verbally describes the role of advocate with respect to people with developmental disabilities.

2. Assist client in identifying the source of a problem and potential solution(s).

3. Assist client in implementing solution, with the client carrying as much of the active role as possible, and speaking for the client when required to obtain a just resolution.

4. Identify resources needed, resources available, and select one(s) appropriate to the problem.

5. Assess living, educational, vocational, recreational aspects of life for an institutionalized person to determine the extent to which the client is receiving the best available service.

6. Advocate on behalf of the client with a particular service delivery system after having assessed that it is necessary to do so.

## J. Supervises and Administers People and Programs

1. Cite and discuss the conditions requisite for effective service to exceptional individuals and their families.

2. Describe four general strategies for socially involving institutionalized residents, now living in an ALA, and their families in the community.

3. Present a plan for establishing an ALA in a community that would evoke minimum attention to the ALA and its residents, given a specific set of data.

4. Detail the procedure for assessing particular generic services.

5. Evaluate in detail a local community resource designed to assist exceptional individuals in developing competencies to meet their social, emotional, career, physical and educational needs.

6. Given specific data, plan an ALA for a given location with a specified number of staff and a particular number of exceptional individuals so that the best possible service is provided to residents within a typical budget.

7. Given specific data, plan a three-month staffing schedule.

8. Describe a program review system that could be implemented in an ALA that would ensure that each resident is continually receiving training and other services that reflect his/her strengths and needs.

9. Describe the necessary functions of a supervisor.

10. Given specific data, establish the performance requirements of a resident advisor in a particular ALA.

11. Given specific data, conduct a performance review with an ALA staff member.

12. Interview prospective staff members and select one who is best qualified to fill a vacancy in a particular ALA, given specific data.

13. Prepare an orientation program for three new staff members in a particular ALA, given specific data.

14. Prepare and implement a training program for one staff member in a specified skill common to resident advisors.

15. Given specific data, prepare a budget for one year for an ALA.

16. Verbally identify and describe the impact of any legislation that affects the physical plant or the operation of an ALA in a specified geographical area.

17. Given specific data, plan work assignments for the staff of an ALA for six months.

18. Given specific data, establish a communication system that meets the needs of a specific ALA.

19. Given specific data, conduct an interview which results in the termination of an unsatisfactory staff member.

20. Given specific data, intercede in a dispute between two staff members of an ALA.

21. Conduct a staff meeting in an ALA.

22. Identify three major theories of leadership, and describe each.

23. Given specific data, present three alternatives for handling a leadership situation, articulating the advantages and disadvantages of each. Select one, and give a rationale for the selection.

24. Given specific data, write:

    a. a performance appraisal for a staff member
    b. a summary of progress for a resident
    c. a year-end operations report
    d. a justification for an additional staff member
    e. a justification for additional funds
    f. entry and exit criteria for an ALA.

# APPENDIX F

Mental Retardation Counselor Program

## SUBJECTIVE EVALUATION, MR-203-3, MR-204-4, MR-308-L

STUDENT ______________________________ Final Evaluation

PLACEMENT AGENCY ______________________________ Interim Evaluation

MODULE ______________________________

DATES ______________________________

SUPERVISOR ______________________________

For First Year Students (MR-203-3, Winter Semester, and MR-204-4, Spring), this is the only evaluation form to be used.

For Second Year Students (MR-308-L, Winter Semester), this form must be used in conjunction with the appropriate Competency Checklist.

Please evaluate the student in relation to each item, using both the numerical scale below, and a verbal description. Feel free to use page 4 for additional observations. This evaluation should be completed before the student's final placement day. It must be reviewed by the student face to face. At the same time, the student's Self-Evaluation should be discussed. Both the evaluator and the student should sign each evaluation.

KEY:
10 = Excellent
5 = Pass
1 = Very inadequate

1. Quality of relationships with clients (discuss)

1 2 3 4 5 6 7 8 9 10

2. Relationships with staff (individuals, team):

1 2 3 4 5 6 7 8 9 10

---

3. Initiative and Independence:

1 2 3 4 5 6 7 8 9 10

---

4. Professional competence and Judgement

1 2 3 4 5 6 7 8 9 10

---

5. Recognition of clients' needs:

1 2 3 4 5 6 7 8 9 10

---

6. Creativity/resourcefulness:

1 2 3 4 5 6 7 8 9 10

---

7. Self-confidence (balance of):

1 2 3 4 5 6 7 8 9 10

---

8. Dependability and Responsibility:

1 2 3 4 5 6 7 8 9 10

---

9. Areas of Strength: (list)

---

10. Would you work with this person for an extended period of time? Why or why not?

---

11. Ability to function in a group (clients or staff)

1 2 3 4 5 6 7 8 9 10

---

12. Other areas, comments, etc.

---

Days Absent ____________________

Competency sheet ( ) Evaluation ( ) Self-evaluation ( ) Log ( )

SUPERVISOR'S SIGNATURE

STUDENT'S SIGNATURE

DATE ____________________

I agree to the release of this evaluation to:

AGENCY

STUDENT

# APPENDIX G

## Mental Retardation Counselor Program

## SELF EVALUATION, MR-203-3, MR-204-4, MR-308-L

(to be completed by the student)

Student

Placement Agency

Module

Dates

Supervisor

Each topic area should be considered and a brief comment made about yourself in relation to that item. These comments should be shared with your supervisor prior to your last day of placement; the student and the supervisor should both sign this form. Other items may be added.

Circle the number that represents your level of achievement for each item, using the following key:

10 = Excellent
5 = Pass
1 = Very inadequate

1. Quality of relationships with clients: Discuss

1 2 3 4 5 6 7 8 9 10

2. Relationships with staff (individuals, team):

1 2 3 4 5 6 7 8 9 10

---

3. Initiative and independence:

1 2 3 4 5 6 7 8 9 10

---

4. Professional competence and judgement:

1 2 3 4 5 6 7 8 9 10

---

5. Recognition of clients' needs:

1 2 3 4 5 6 7 8 9 10

---

6. Creativity/resourcefulness:

1 2 3 4 5 6 7 8 9 10

---

7. Self-confidence (balance of):

1 2 3 4 5 6 7 8 9 10

---

8. Dependability, responsibility:

1 2 3 4 5 6 7 8 9 10

---

9. Ability to function in a group (clients or staff)

1 2 3 4 5 6 7 8 9 10

---

10. Would you work as a staff member in this agency?
Why or why not?

---

11. Value of this placement:

1 2 3 4 5 6 7 8 9 10

---

12. Comments:

---

Student's Signature

Supervisor's Signature

Date: ______________________

## APPENDIX H

### Mental Retardation Counselor Program

### MR-308-L - Field Placement 3

### MULTI-HANDICAP MODULE COMPETENCY CHECKLIST

**Name** ______________________ **Dates** ______________________

**Agency** ______________________________________________

**Supervisor** ______________________ **Faculty** ______________________

**Key:**

C = Competent
O = Not Competent
E = Exceeds requirements

Enter the letter corresponding to your evaluation in the column "Final Level." If you wish to make an interim evaluation, use the "Interim Level" column.

| SKILLS | Interim Level | Final Level |
|---|---|---|
| 1. Identifies symptoms, associated medical problems, and appropriate care for various physical handicaps: (list) | | |
| a) | | |
| b) | | |
| c) | | |
| d) | | |
| 2. Uses applicances appropriately: | | |
| a) Wheelchairs | | |
| b) Walkers | | |
| c) Crutches | | |
| 3. Uses appropriate lifting techniques. | | |
| 4. Positions properly: | | |
| a) To prevent contracture | | |
| b) For comfort | | |
| c) For maintenance of normal body posture | | |

| SKILLS | Interim Level | Final Level |
|---|---|---|
| *5. Care for prostheses: | | |
| a) artificial limbs | | |
| b) false teeth | | |
| c) hearing aid | | |
| d) eye glasses | | |
| e) braces | | |
| 6. Teaches care of prostheses | | |
| 7. Uses comfort devices | | |
| 8. Initiates relaxation procedures: | | |
| a) Individual | | |
| b) Group | | |
| 9. Recognizes epileptic seizures: | | |
| a) grand mal | | |
| b) petit mal | | |
| c) psychomotor | | |
| 10. Provides appropriate care following epileptic seizures: | | |
| a) grand mal | | |
| b) petit mal | | |
| c) psychomotor | | |
| 11. Provides required hygiene. | | |
| 12. Uses appropriate feeding techniques. | | |
| 13. Teaches self-help skills: | | |
| a) dressing | | |
| b) toileting | | |
| c) grooming | | |

* where applicable

| SKILLS | Interim Level | Final Level |
|---|---|---|
| 14. Performs exercises: | | |
| a) passive | | |
| b) restive | | |
| c) active assistive | | |
| 15. Initiates low organization games. | | |
| 16. Initiates control of movement. | | |
| 17. Helps develop sensorimotor skills: | | |
| a) body awareness | | |
| b) space and direction | | |
| c) balance | | |
| d) limb coordination | | |
| e) basic locomotion | | |
| f) crawling | | |
| g) walking | | |
| 18. Encourages social skills: | | |
| a) awareness of others | | |
| b) contact with others | | |
| c) interaction with others | | |
| d) cooperation with others | | |

Student's signature ________________________________

Supervisor's signature ________________________________

SUPERVISOR'S COMMENTS:

________________________________
________________________________
________________________________
________________________________
________________________________
________________________________
________________________________

STUDENT CONSENT: I agree to the release of this evaluation to

________________________________
agency

________________________________
Student Signature

## Mental Retardation Counselor Program

MR-308-L
Family Care Module

## SKILL PERFORMANCE RATING

C = Competent
O = Not Competent
E = Exceeds Requirements

Final Assessment Key: L - Simulation Lab
A - Agency

| | C | O | E |
|---|---|---|---|
| 1. Washes hands as necessary using good technique | | | |
| 2. Makes a comfortable unoccupied bed | | | |
| 3. Makes a comfortable occupied bed | | | |
| 4. Assesses and records accurately | | | |
| Temperature ) - oral | | | |
| ) - auxillary | | | |
| Pulse ) - radial | | | |
| ) - carotid | | | |
| Respiration | | | |
| 5. Care of equipment for vital sign assessment | | | |
| 6. Provides hygienic care of: | | | |
| Skin ) - Tub, shower | | | |
| ) - Bed bath | | | |
| Mouth, dentures | | | |
| Hair | | | |
| Eyes | | | |
| Nails | | | |
| 7. Feeds a patient | | | |
| 8. Assists an individual with dressing and undressing | | | |
| 9. Lifts and moves patient in a safe, comfortable manner, utilizing those principles of physics related to body mechanics: | | | |
| a) from floor to bed or chair | | | |
| b) from one side of the bed to the other | | | |
| c) from bed to stretcher, vice versa | | | |
| d) from bed to chair, vice versa | | | |

C O E

9. (cont'd)
    e) up in bed
    f) from a supine position to a sitting position
    g) from a sitting position to supine position
    h) in and out of a bathtub
    i) from a wheelchair to chair or toilet

10. Positions a patient using appropriate devices in the position of:
    a) Fowler's
    b) Supine
    c) Lateral

11. Provides Range of Motion Exercises (Active and Passive) as required and/or in simulated Laboratory situations.

12. Places a patient on a bedpan in bed and removes

13. Tests urine for sugar and acetone

14. Prepares, administers and records
    a) eye drops
    b) eye ointment
    c) suppositories

15. Prepares, administers and records:
    a) tablet medication
    b) liquid medication

16. Identifies and explains the equipment required for:
    a) administration of oxygen
    b) administering an enema fleet, soap suds
    c) suctioning
    d) shampoo in bed
    e) application of heat
    f) application of cold

17. Demonstrates:
    a) application of heat
    b) application of cold

| | C | O | E |
|---|---|---|---|
| 18. Changes a dressing and/or care of decubitus ulcer | | | |
| 19. Care of equipment and supplies: | | | |
| 20. TOTALS | | | |

DATE: ____________________

STUDENT: ____________________

INSTRUCTOR: ____________________